MEDICAL RECORD — Progress Note

NOTE DATED: 04/20/2007 15:55
LOCAL TITLE: COMPENSATION AND PENSION NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 04/20/2007 15:00 ZZZcp mhc santos
EXAM TYPE: Stress disorder compensation and pension.

GENERAL DATA: Mr. Stanley Laskowski III is a 29-year-old white male, married, who lives in Dunmore, Pennsylvania.

SOURCES OF INFORMATION:
A. Review of C-folder.
B. Electronic records at the Wilkes-Barre VA Medical Center.
C. Self report.

MEDICAL AND OCCUPATIONAL HISTORY: PSYCHIATRIC - Besides his one and only visit so far at Mental Hygiene Clinic in Wilkes-Barre VA Medical Center on April, 11, 2007 for complaints of sleep disturbance, he has had no other history of contact with mental health the whole time, premilitary as well as while in the military.

He admits to drinking alcohol, consuming on the average a 6-pack of beer a month. He denies use of illicit drugs currently.

He did have history of illicit drug use before he joined the military service, using drugs like marijuana, cocaine, and LSD but never needles. He had ceased using drugs and has never had any for at least the past 8 years.

He has had minor infractions with the law before he joined the military service. One time he was charged with receiving stolen property. He was put on probation but was dropped because it was his first offense. He also had been involved in minor drug busts and traffic tickets for speeding.

MEDICAL HISTORY - He is in relatively good physical health. He is not on any medications currently for medical indications.

He had a right arm injury in 2002 while stationed in Okinawa, after he fell from the stairs. He was apparently inebriated from alcohol when this occurred.

PERSONAL AND SOCIAL HISTORY: He was an only child. His parents divorced when he was about 2 years of age. He lived with his mother until about 5 years of age. He described his mother to be a substance abuser who uses alcohol and drugs. His father too was an excessive alcohol drinker. From the age of 6 to 7 years old he was under the care of his father's sister and from 8 years old until he reached adulthood he was under the custody of his father, who got married to his stepmother in 1985.

He went to high school at Bishop O'Hara in Dunmore, Pennsylvania, graduating in 1996. He had good grades prior when he was in grade school, about decent grades in high school as he reported. When he was in high school he used to hang out with the "stoners". He had some behavioral issues at that time, having fights with classmates leading to school suspension.

For the next 3 years after finishing high school he went into a period of endless lifestyle, having odd jobs, using drugs, and chasing women. He finally realized that his life is not going anywhere and wanting since high school to be a Marine, like his father who served the Marines, he enlisted in 1999 into the US Marine Corp. He served a total of 8 years of active duty until 2007.

During the start of the Iraqi Freedom War, he was a member of the invasion forces of the 3rd Battalion 5th Marine 1st Marine Division as a squad leader. He had a total of about 5-6 months in Iraq and he participated from the time his unit started from

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Note

NOTE DATED: 04/23/2007 10:30
LOCAL TITLE: COMPENSATION AND PENSION NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 04/23/2007 10:30 ZZZCP AUDIO PATCHOSKI
AUDIOMETRIC COMPENSATION AND PENSION EXAMINATION

DATE OF EXAMINATION: April 23, 2007

SECTION A. REVIEW OF MEDICAL RECORDS:

The veteran's C-file was reviewed prior to this Audiometric Compensation and Pension Examination to find reference to puretone audiometry throughout the veteran's active duty military service from 1999 to February 5th, 2007. Reference to normal hearing sensitivity was noted in 1999, and a slight but significant threshold shift was noted in 2005 following deployment Iraq. This threshold shift noted in 2005 was consistent with noise exposure and was primarily in the right ear. It was borderline mild high frequency hearing loss that was diagnosed at that time.

SECTION B. MEDICAL HISTORY:

SUBJECTIVE COMPLAINTS: The veteran reports experiencing a constant bilateral tinnitus attributed to his combat military service while in Iraq in 2003. He reports many instances of combat noise explosions, et cetera, which he feels are responsible for the current condition related to tinnitus. He is unsure as to the status of his hearing sensitivity but does report that at times understanding conversational speech in challenging listening environments may become difficult. He denies a history of chronic ear disease, vertigo, gait, or balance disorders. He also denies a histroy of civilian occupational or recreational noise exposure.

SECTION C. PHYSICAL EXAMINATION:

OBJECTIVE FINDINGS: Right Ear: 500 Hz: 5 dB, 1000 Hz: 5 dB, 2000 Hz: 5 dB, 3000 Hz: 5 dB, 4000 Hz: 20 dB; four frequency average: 9 dB. Left Ear: 500 Hz: 5 dB, 1000 Hz: 5 dB, 2000 Hz: 5 dB, 2000 Hz: 5 dB, 3000 Hz: 5 dB, 4000 Hz: 20 dB; four frequency average: 9 dB.

Speech Recognition Score: 100% right ear, 100% left ear.

SECTION D. DIAGNOSTIC AND CLINICAL TEST RESULTS:

An otoscopic examination finds both external auditory canals to be free and clear of excessive cerumen, allowing a complete visual inspection of both tympanic membranes which appear to be normal and intact.

Speech reception threshold, speech recognition, puretone air conduction threshold, bone conduction threshold, tympanometry, and acoustic reflexes are otherwise indicative of essentially normal hearing sensitivity.

SECTION E. CONCLUSIONS AND DIAGNOSES:

SUMMARY OF TEST RESULTS: Puretone audiometric test results reveal normal hearing sensitivity at 250-8000 Hz in a symmetrical hearing configuration. The once noted mild hearing loss related to noise exposure evidenced in c-file in 2005 has improved to normal levels suggesting that previous results were as a result of a temporary threshold shift. However, thresholds at 4KHz. are elevated when compared to the rest of the configuration and though it is still within normal limits, it does reflect a change from initial examination dated 1999.

Middle ear function is normal, and acoustic reflexes are obtained at levels consistent with the puretone audiometric configuration.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

04/24/2007 08:32 ** CONTINUED FROM PREVIOUS PAGE **

Signed by: /es/ DOMINIC E CASTRIGNANO, DO
STAFF PHYSICIAN PRIMARY CARE
05/10/2007 12:41

M202

THROAT: Normal Oro-Pharyngeal Mucosa.

NECK: Supple / NO Masses / NO Thyromegaly.
NO Carotid Artery Bruits/Jugular Vein Distention.

LUNGS: Clear / NO Cough, Wheeze, Dyspnea.

HEART: Rate 72-76 / Regular S1-S2 / NO Murmur.

VASCULAR: Palpable Peripheral Pulses.
NO Signs of Arterial Ischemia/Venous Insufficiency.

ABDOMEN: Non-Tender / NO Masses.

RECTAL: DEFERRED.

GENITAL: DEFERRED.

MUSCULO-SKELETAL: 5/5 Motor Power Upper & Lower Extremities.

NO Spine Pathology Noted.
Normal Mobility in Cervical & Lumbo-Sacral Spine.

JOINT PATHOLOGY NOTED.
SEE ORTHOPEDIC/JOINTS C/P EXAM.
SEE PODIATRY/FEET C/P EXAM.

NEURO: Cranial Nerves II-XII Intact.
Symmetric 2+ Reflexes / Normal Coordination.
NO Focal Sensory/Motor Deficits.

PSYCH: CLAIMS POST-TRAUMATIC STRESS DISORDER.
SEE PSYCHIATRY/STRESS DISORDER C/P EXAM.

D. DIAGNOSTIC AND CLINICAL TESTS.

1. CHEST X-RAY: NO Acute/Chronic Lung Disease.
2. URINALYSIS: NEGATIVE Protein, Glucose, Ketones, Blood.
3. COMPLETE BLOOD COUNT: Within Normal Limits.
4. BLOOD CHEMISTRY: Fasting Blood Glucose 114
Blood Urea Nitrogen 8 / Creatinine 1.1
5. X-RAY SINUSES:
Report:
Paranasal sinuses
The examination reveals satisfactory development of the maxillary, ethmoid, frontal and sphenoid sinuses. The sinuses are clear and well aerated revealing no mucosal thickening, mass densities or retained fluid. The osseous margins are intact.
Impression:
Normal Paranasal Sinus study.

E. DIAGNOSIS.

1. CHRONIC SINUSITIS.
2. SEE AUDIOLOGY C/P EXAM.
3. SEE DERMATOLOGY/SKIN C/P EXAM.
4. SEE ORTHOPEDIC/JOINTS C/P EXAM.
5. SEE PODIATRY/FEET C/P EXAM.
6. SEE PSYCHIATRY/STRESS DISORDER C/P EXAM.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD

Progress Not

04/24/2007 08:32 ** CONTINUED FROM PREVIOUS PAGE **

EYES: NO Vision Problem Noted.
Pupils Equal/Reactive to Light.
Extra-Ocular Muscles Intact.

EARS: CLAIMS HEARING LOSS/TINNITUS.
SEE AUDIOLOGY C/P EXAM.
External Canals Patent / NO Discharge.
Tympanic Membranes Intact / NO Scarring.

NOSE: Septum Midline / Turbinates Patent / NO Discharge.

SINUSES: CLAIM FOR SINUS CONDITION -
==========
MEDICAL HISTORY/SINUSES.
ONSET: DURING Active Military Service.
CIRCUMSTANCES: August, 2005 at Paris Island.

LOCATION/NATURE OF INJURY/DISEASE: Frontal/Peri-Orbital Sinuses.

TREATMENT -
SURGERY: None.
MEDICATIONS/RESPONSE/SIDE EFFECTS:
Anti-histamine treatment at Paris Island with relief of sinus pains/NO side effects.

SUBJECTIVE COMPLAINTS -
==========
INTERFERENCE BREATHING THROUGH NOSE: No.

WATERY DISCHARGE FROM NOSE: No.
PURULENT DISCHARGE FROM NOSE: Yes - Periodic yellowish discharge.

DYSPNEA AT REST: No.
DYSPNEA ON EXERTION: No.

SINUS PAIN: Yes - Frontal & Peri-Orbital.
SINUS HEADACHES: No.

NASAL ALLERGIC ATTACKS: None.
SINUS ALLERGIC ATTACKS: None.

OTHER SYMPTOMS: None.

PERIODS OF INCAPACITATION REQUIRING BED REST AND TREATMENT BY A PHYSICIAN: None.

FUNCTIONAL IMPAIRMENT RELATED TO NOSE/SINUS CONDITION -
==========
USUAL OCCUPATION: Consultant for John Hancock.
NO affect on work.
ACTIVITIES OF DAILY LIVING: NO Affect.

PHYSICAL EXAMINATION/SINUSES.
NOSE -
======
SEPTAL DEVIATION: None.
NOSTRIL INFLAMMATION: None.
NOSTRIL DISCHARGE: Yes - Yellowish Mucus.
NOSTRIL OBSTRUCTION: None.
NASAL POLYPS: None.
RHINOSCLEROMA: None.

SINUSES -
=========
TENDERNESS: None.
PURULENT DISCHARGE: Yes.
CRUSTING: None.

M204

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Note

NOTE DATED: 04/24/2007 08:32
LOCAL TITLE: COMPENSATION AND PENSION NOTE
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 04/24/2007 08:00 ZZZCP CASTRIGNANO

GENERAL MEDICAL EXAM

A. REVIEW OF MEDICAL RECORDS.

CLAIMS FILE Reviewed.

The medical records of the Wilkes-Barre VA Medical Center were reviewed.

This veteran claims Service Connection for the following injuries and diseases found OCCURRED DURING ACTIVE SERVICE:

1. Skin Rashes.
2. RIGHT Hip Bursitis.
3. RIGHT Arm Fracture.
4. Chronic LEFT Hip Pain.
5. SINUSITIS.
6. RIGHT Heel Spur.
7. Hearing Loss.
8. Tinnitus.
9. Post-Traumatic Stress Disorder.

B. MEDICAL HISTORY.

OCCUPATION HISTORY -
USUAL OCCUPATION: Consultant for John Hancock.
WORK TIME LOST DUE TO HEALTH PAST 12 MONTHS: Yes.
ABSENT from work 3 days due to RIGHT Hip Bursitis Pain.

ACTIVE CONDITIONS/CURRENT TREATMENT:

RIGHT HIP BURSITIS -
Motrin 800mg twice a day / NO pain relief / NO side effects.

POST-TRAUMATIC STRESS DISORDER -
Trazodone 25mg daily at bedtime / Adequate sleep response.
WITH Side Effect of nausea, vomiting the next day.
Veteran stopped taking Trazodone due to side effect.

SURGERY/HOSPITAL HISTORY:

1994 - Admission for Concussion due to Motor Vehicle Accident.

C. PHYSICAL EXAMINATION.

GENERAL: 29 Year Old Male in NO Acute Physical Distress.

VITAL SIGNS:
BLOOD PRESSURES: 136/81, 118/75, 132/86
PULSE: 72
RESPIRATION: 18
HEIGHT: 5'8"
WEIGHT: 180

DOMINANT HAND: RIGHT Handed for Writing & Working.

POSTURE/GAIT: Normal Posture / Steady Gait.

SKIN: SEE DERMATOLOGY/SKIN C/P EXAM.

HEAD: Atraumatic/Normocephalic.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Note

NOTE DATED: 05/11/2007 13:00
LOCAL TITLE: NSG NURSING NOTE(T)
STANDARD TITLE: NURSING NOTE
VISIT: 05/11/2007 13:00 ZZZMHC LUCAS INTAKE
Vital Signs:

TEMPERATURE: 98.8 F [37.1 C] (04/26/2007 14:06)
PULSE: 92 (04/26/2007 14:06)
RESPIRATION: 20 (04/26/2007 14:06)
BP: 136/76 (04/26/2007 14:06)
PAIN: 5 (04/26/2007 14:06)

DATA:

ASSESSMENT:

PLAN:
Preventive Health Screen:
Annual Preventive Health Screen Information

ALTERNATIVE THERAPY INFORMATION
No Herbal/Alternative Therapy taken.
Patient is taking Over The Counter medications.
OTC Meds: exedrin,niquil
HYPERTENSION/OBESITY
Patient's BMI is <21 or >25. Current BMI: 27.4
Patient has been diagnosed with hypertension, diabetes mellitus or has a BMI <21 or >25. Indicate if patient has been evaluated by a dietitian in the past year.
Patient HAS NOT been evaluated by a dietitian in the past year.
Patient declines Nutrition Clinic consult.

ALLERGY INFORMATION
Patient states 'No Known Allergies". Primary Care provider must enter this information in CPRS.
SAFE IN HOME ENVIRONEMENT QUESTIONS
Patient feels safe in home environment.
PULMONARY
Patient does not use an inhaler/nebulizer.
ADL QUESTIONS
Patient DOES NOT need assistance with ADL.
Patient reports NO decrease/loss of self-care skills within past month.
Patient reports NO decrease/loss of mobility within past month.
Patient reports NO difficulty in swallowing.
DIABETES QUESTIONS
Patient IS NOT diabetic.
SEATBELT/HELMET SAFETY QUESTIONS
Do you wear a seatbelt when driving or riding in a car?
Comment: Yes
Do you wear a helmet when riding a motorcycle or bicycle?
Comment: NOT APPLICABLE

PREVENTIVE HEALTH EDUCATION SECTION
Education Topic & Level of Understanding

Signed by: /es/ MARC A KOVALCHIK
MSNRN
05/11/2007 13:05

M 206

MEDICAL RECORD — Progress Note

05/11/2007 13:11 ** CONTINUED FROM PREVIOUS PAGE **

Sees things upon awakening and falling asleep, have to do with combat experiences
THOUGHT PROCESS AND ASSOCIATION:
normal, coherent
THOUGHT CONTENT (delusions, obsessions etc.):
no unusual thought content
details: Very focused on things at times
SUICIDAL OR VIOLENT IDEATION:
none
INSIGHT:
good
JUDGMENT:
good
impulsive
MEMORY:
intact
FUND OF KNOWLEDGE
Above Average
MENTAL STATUS COMMENTS:
Patient with NM, FB, intrusive thoughts, irritability, anger and sleep disturbance
SUMMARY AND FORMULATION:

Patient with PTSD and depressive symptoms.

INITIAL DSM-IV DIAGNOSIS:

Axis I Clinical Disorder:
Anxiety Disorder: PTSD,chronic
Depressive Disorder; NOS (Not Otherwise Specified)
Axis II Personality Disorders/Traits:
None
Axis III Current Medical Conditions: See Medical History above
Axis IV Current Psychosocial Stressors:
social environment

Axis V GAF Score (current level of functioning): 65
Initial Treatment Plan:
Patient will try Clonazepam 0.5mg at HS for sleep, Buproprion at 100mgg in AM for irritability and anger, follow up in two months, refer to Psychology for PTSD follow up.
Long Term goals Reduce symptoms increase coping, improve sleep

Anticipated Duration:Chronic/Ongoing

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
05/11/2007 13:48

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
05/11/2007 14:10

M207

MEDICAL RECORD Progress Note

05/11/2007 13:11 ** CONTINUED FROM PREVIOUS PAGE **

f) Relevant community resources accessed by patient:
Kids are on CHIP

MILITARY HISTORY:
Branch:
Joined the US Marines in 1999, Parris Island, Camp Pendleton, back to Parris island as a rifle instructor. To Iraq in 2003, Combat, in invasion force as a member of the infantry, much action, there six months, small arms, artillery and other explosions were part of experience. Saw a house explode and the remains of a six month old baby, saw another Marine killed in front of him. Has other random memories like the first bullet whizzing past his head. Left and returned to Parris island and was honorably discharged in 2/6/07. Rank was Sergeant, has Combat Action Ribbon, OIF medal, GWAT medals, 2 NAMPS, one with combat valor.

MEDICAL INFORMATION

(include response to medications, any medication side effects)
a) CURRENT MEDICAL PROBLEMS: Back Pain, Other Sleep Disorders, Other (specify)
Disrupted sleep problems

b) CURRENT SIGNIFICANT PAIN PROBLEMS: Yes
Stomach pain

c) NUTRITION ASSESSMENT: Well developed, well nourished

d) CURRENT VA-PRESCRIBED MEDICATIONS:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	TABLET SPLITTER USE AS DIRECTED FOR TABLET SPLITTING	ACTIVE
2)	TRAZODONE 50MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME MAY START AT 1/2 TAB	ACTIVE

e) CURRENT NON-VA MEDICATIONS:
Excedrin for headache

f) CURRENT NICOTINE AND CAFFEINE USE:
Smokes 1 PPD for 14 years, coffee at a pot a day

ALLERGIES AND ADVERSE DRUG REACTIONS:
Patient has answered NKA

MENTAL STATUS EXAM:
ORIENTATION AND CONSCIOUSNESS:
alert and attentive
oriented x3
APPEARANCE AND BEHAVIOR:
cooperative and reasonable
grooming appropriate
SPEECH:
normal rate/rhythm
LANGUAGE:
intact
MOOD AND AFFECT:
affect is congruent with mood
affect is wide range
mood anxious
PERCEPTUAL DISTURBANCE (hallucinations, illusions):
Other: Hypnopompic and hypnogogic experiences
details:

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

NOTE DATED: 05/11/2007 13:11
LOCAL TITLE: PSYCH INTAKE ASSESSMENT
STANDARD TITLE: PSYCHIATRY INPATIENT NOTE
VISIT: 05/11/2007 13:00 ZZZMHC LUCAS INTAKE
MRC Approved 3/15/05
Job # 05-05

Age: 29 GENDER: MALE RACE: WHITE
MARITAL STATUS: Married.

CLINICAL HISTORY

PRESENTING CHIEF COMPLAINT:
I get angry and irritable.

HISTORY OF CURRENT ILLNESS:
I went to the USMC and ultimately ended up in Iraq for the invasion. I saw some things that stay with me. They come out of nowhere and it makes me angry and upset with the people I love.

PAST PSYCHIATRIC HISTORY:
I came in once about a month ago because I couldn't sleep for about three days. This happens twice a month to twice a week sometimes.

HISTORY OF SUICIDAL ACTS AND SELF-HARM:
None

HISTORY OF VIOLENCE/ASSAULTING OTHERS/LEGAL PROBLEMS:
Receiving stolen property was removed due to probation.

SUBSTANCE USE HISTORY:
Prior to military was involved in marijuanna and cocaine, alcohol he was drinking a twelve pack a night. Stopped drugs prior to Marines, slowed down with alcohol since about 2003, social drinker now, occasional binge.

MENTAL ILLNESS AND SUBSTANCE ABUSE IN FAMILY MEMBERS:
Mother was drug addict and alcoholic, many rehabs, dad was alcoholic.

PSYCHOSOCIAL HISTORY:
a) Childhood/Developmental History: Was suspended from school for fighting, HS grad, 2 years of college with no degree, dad was domestic abuser.

b) Adult Relationship History: Outgoing in HS, no problems meeting people, since he returned more careful of meeting people. Heterosexual preference

c) Current significant family and/or peer group relationships:
Dad there for him, his wife also. Has a cousin Ron who is engaged.

d) Financial Status, Housing, Employment, Leisure Time Issues: Good finances, rents, Keystone Financial Mgt. since Mar 24, 07, as an advisor, works for fun, out to eat, sped time with kids, TV, music.

e) Religious/Spiritual or Cultural Issues that might influence treatment:
None

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

NOTE DATED: 05/16/2007 07:49
LOCAL TITLE: SCANNED C&P
STANDARD TITLE: SCANNED NOTE
VISIT: 05/16/2007 07:49 FILEROOM
to view see vista imaging display

Signed by: /es/ RICHARD G BRIDLE
file clerk/scanner
05/16/2007 07:49

M210

MEDICAL RECORD Progress Not

NOTE DATED: 05/17/2007 15:01
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 05/17/2007 15:00 ZZZMHC PIERCE
Pt called today. He says bupropion made him feel very anxious like he wanted t put his head through a window. He c/o NM, FB, irritability, and anxiety. Will d/c wellbutrin. Will try paxil 10 mg x one wk, then 20 mg daily. Side effects and expected benefits were discussed with the patient. He was encouraged to call if there were any problems. He was appreciative of the call.

Signed by: /es/ JENNIFER E PIERCE, PA-C
Physician Assistant
05/17/2007 15:03

Receipt Acknowledged By:
/es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
05/22/2007 08:27

M211

MEDICAL RECORD

Progress Not

NOTE DATED: 05/31/2007 10:35
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 05/31/2007 10:35 TLCP PSYCHIATRY
Patient tried the Paroxetine and felt like he was crawling out of his skin. Stopped the med. He is able to sleep at night without nightmares on the Clonazepam but has daytime anxiety. Will try Clonazepam 0.25mg BID for this weekend and see the result on daytime anxiety. Patient agrees and will call nex week with result.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
05/31/2007 10:37

M212

MEDICAL RECORD Progress Note

NOTE DATED: 06/04/2007 14:01
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 06/04/2007 14:00 TLCP PSYCHIATRY
Has tried the Clonazepam over the weekend and has not noted much change on the 0.25mg dose BID, tried 0.5mg dose once and didn't notice any changes. Will make dose 0.5mg BID until he is seen on 7/3/07. Patient is satisfied.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
06/04/2007 14:03

M213

MEDICAL RECORD — Progress Note

NOTE DATED: 06/22/2007 10:25
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 06/22/2007 10:25 TLCP PSYCHIATRY
Patient called about the clonazepam making him tired in the daytime. He is sleeping much better and feels great when he gets up but, once he takes the daytime clonazepam, he gets sleepy four hours later. His sex drive is down as well. Told to stop the daytime dose of the Clonazepam and will discuss alternatives on his next visit in July. He is satisfied.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
06/22/2007 10:27

M214

MEDICAL RECORD — Progress Note

NOTE DATED: 07/03/2007 13:00
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 07/03/2007 13:00 ZZZMHC LUCAS

Chief Complaint: Medication and symptom management.

Subjective: "The Paxil medication made me feel really stimulated and anxious. I felt like I was going to crawl out of my skin. I got extremely irritable and angry with it. I stopped the medicine and then got sick to my stomach and had headaches for a couple days. That is just not the stuff for me. I still have anger and irritability, but my sleep is improved. I am able to sleep all night. I wake up refreshed and with enough energy to make it through the day. I really would like to work on the anger and irritability during the day, but I am unsure what approach to take. I have no thoughts of hurting myself or anyone else. I do look forward to every day and work hard at my job."

Mental Status Examination: The patient is alert, oriented x3. Speech is appropriate in content, normal in rate and tone. Thoughts are organized. Content is appropriate, somewhat negative. The patient denies any auditory or visual hallucinations. Judgment and insight are good. Mood is mildly depressed, somewhat anxious affect. The patient denies any suicidal or homicidal idation. The patient has no involuntary movements.

Objective: Patient with attempts at utilization of trazodone, paroxetine, and Wellbutrin over a two-month period. Failures on all medications due to stimulating or extremely sedating side effects. The patient appears to be a slow metabolizer. The evening dose of clonazepam works well to maintain normal sleeping pattern of six to eight hours, and he wakes up refreshed, unable to take day time clonazepam due to sedation during the day. The patient has no suicidality. The patient continues with some irritability and anger. The patient also has some intrusive thinking during the day. No suicidality.

Plan: Discontinue the paroxetine. We will start buspirone 5 mg twice daily and will taper up over a few months. Hopefully medication will have calming effect similar to clonazepam without the sedation. Side effects of the medication were discussed with the patient. He agrees to utilize the medicine. The patient was encouraged to call if there are any problems, side effects, symptoms worsen, or he feels unsafe. Rescheduled at first available after fourteen days. The patient is satisfied. Time of appointment was 30 minutes.

D: 7/3/07 1:26P T: 7/3/07 T16 #52332

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
07/10/2007 10:21

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
07/10/2007 10:31

M215

Progress Note

MEDICAL RECORD

NOTE DATED: 07/03/2007 13:27
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 07/03/2007 13:00 ZZZMHC LUCAS
PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above.
Comment: Buspirone

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
07/03/2007 13:31

M216

MEDICAL RECORD Progress Note

NOTE DATED: 07/16/2007 15:31
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 07/16/2007 15:29 TLCP PSYCHIATRY
Patient called and stated he is more irritable on the BusPar medication. He has stopped it. He increased the Clonazepam to 1mg at HS and 0.5mg in the day and it works good for sleep and anxiety. We discussed talking about changes in medication prior to starting them, it is the provider's decision about effectiveness that constitutes rationale for changing doses. He has not adequately trialed any of his psychiatric medications and has been on Trazodone, Buproprion, Paroxetine and Buspirone alternately since 4/11/07. Each time the medication caused an adverse behavioral effect such as self harm, irritability, restlessness. Responds positively to benzodiazepines as they are sedative and were intended as an interim medication until his antidepressant medication was titrated to effective dose. Will continue current Clonazepam 0.5mg in AM, 1mg at HS as it has been effective thus far for anxiety and sleep until seen by Dr Bhatia for case review.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
07/16/2007 15:42

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
07/16/2007 15:44

M217

MEDICAL RECORD — Progress Notes

NOTE DATED: 07/18/2007 16:21
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 07/18/2007 16:21 TLCP PSYCHIATRY

Patient's wife Marisol called and said the veteran wanted her to talk to me. She is concerned his irritability and anger have been escalating over the last few weeks. He is mixing alcohol with his medications. He has promised to stop the alcohol but she is not convinced. She has heard him complaining about the medications making him tired, agitated, irritated but she feels he does not take them long enough. He needs to get something started because his mood is deteriorating. Encouraged her to get him to come in as a walk in and attend the appointment. She will do this. Tried calling veteran's cell number to discuss but he is not available.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
07/18/2007 16:27

M218

MEDICAL RECORD — Progress Notes

NOTE DATED: 08/13/2007 12:41
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 08/13/2007 12:40 ZZZMHC LUCAS

Received a call from Patrolman Louis Kline (570-383-1820 or 570-342-9111) of the Olyphant police department requesting availability of inpatient psychiatric treatment concerning the veteran. Officer Kline told no information can be released about any veteran without the veteran's signed authorization. Generally speaking, veterans under arrest or legal obligation are not eligible for inpatient psychiatric admission per WBVA policy. The police would like to provide the veteran treatment in lieu of incarceration and they are looking into VA options. Any psychiatric commitments would need to be evaluated as per state law and approved by the attending Psychiatrist for any veteran. They (the police) will decide how to proceed and call the VA at a later time.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
08/13/2007 13:10

M219

Progress Notes

MEDICAL RECORD

NOTE DATED: 08/31/2007 11:01
LOCAL TITLE: TLCP SOCIAL WORK
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 08/31/2007 11:01 TLCP OIF/OEF

This writer received a phone call from the vet's mother, Carol Laskowski. She states that her son has been incarcerated at the Lackawanna Couny Prison for the past three weeks. He was incarcerated as a result of breaking into a local pharmacy and robbing prescription pain killers. The vet's mother inquired as to whether her son could be transferred to the WBVA for inpatient psychiatric care while he is still an inmate. After conferring with Gene Lucas ,CNP who had origionally received a call from the Olyphant police on this case on 8/13/07, I called Mrs. Laskowski back to inform her that the WBVA cannot accept veterans as inpatients on their psych unit while he is a prisoner in the Lackawanna County Prison System. I did advise her that the Lacka. County prison System has mental health providers that can provide appropriate mental health care to her son while he is serving out his prison sentence. She states that she will discuss same with her son's attorney.

Signed by: /es/ KATHLEEN A COLLELO
SOCIAL WORKER
08/31/2007 11:08

Receipt Acknowledged By: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
08/31/2007 16:11

M220

Progress Notes

MEDICAL RECORD

NOTE DATED: 11/27/2007 15:24
LOCAL TITLE: TLCP PSYCHOLOGY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 11/27/2007 15:24 TLCP PSYCHOLOGY
Received message from veteran requesting information on out pt PTSD TX. Phoned veteran. He stated that he is currently in Coatesville residential PTSD TX and is due to d/c 12/4/07. He expressed interest in setting up out pt tx. Advised veteran to begin attending PCT group on 12/5/07 that will meet weekly on Wednesdays at 630pm, with further assessment for additional interventions TBD. He indicated he will attend.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
11/27/2007 15:28

M221

MEDICAL RECORD Progress Note

NOTE DATED: 12/05/2007 08:44
LOCAL TITLE: NSG CLINIC NOTE
STANDARD TITLE: NURSING OUTPATIENT NOTE
VISIT: 12/05/2007 09:30 NURSE CLINIC 1NORTH
HEIGHT: 68 in [172.7 cm] (04/26/2007 14:06)
WEIGHT: 180 lb [81.8 kg] (04/26/2007 14:06)
BMI: BODY MASS INDEX - APR 26, 2007@14:06:43 27.4
BP: 123/71 (12/05/2007 08:44)
T: 98.8 F [37.1 C] (04/26/2007 14:06)
P: 77 (12/05/2007 08:44)
R: 20 (04/26/2007 14:06)
PAIN: 5 (04/26/2007 14:06)

MEDICATION ALLERGY: Patient has answered NKA
Pt states he has an allergy to:

DATA: Chief Complaint: Reports for C&P BP check. Takes no BP meds.

ASSESSMENT: BP 123/71 HR 77.

PLAN: To continue C&P process.

Influenza Immunization:
Influenza Information
The patient refused administration of the influenza vaccine at this time.

Signed by: /es/ JAN M ROBINSON
RN
12/05/2007 08:47

M222

MEDICAL RECORD — Progress Notes

NOTE DATED: 12/06/2007 10:42
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 12/05/2007 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was "Battle Mind". Group began with a discussion of the effects of military training and combat experiences upon the veteran's psychological functioning, as an adaptive change that maximizes survival in that context. Explored contrast between Battle Mind Fx in combat and problems it causes in psychological and relational Fx, when applied in civilian contexts. Provided instruction on how to identify when Battle Mind may be undermining civilian FX and how to intervene. This veteran shared some of the experience of his symptoms and their impact upon his FX.

A: Veteran displayed restricted affect congruent with mood. He seemed alert and aware. He did not demonstrate SI/HI or A/V hallucinations. His insight and judgment seemed fair. His speech was logical, coherent and sequential. Veteran seemed engaged in TX.

DX: PTSD

P: Continue group therapy scheduled twice weekly for maintenance of coping abilities.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
12/06/2007 10:42

M223

DIAGNOSIS
=========

PTSD REVIEW: MENTAL COMPETENCY

DOES THE VETERAN KNOW THE AMOUNT OF THEIR BENEFIT PAYMENT? Yes
DOES THE VETERAN KNOW THE AMOUNTS OF MONTHLY BILLS? Yes
DOES THE VETERAN PRUDENTLY HANDLE PAYMENTS? Yes
DOES THE VETERAN PERSONALLY HANDLE MONEY AND PAYS BILLS? Yes
IS THE VETERAN CAPABLE OF MANAGING FINANCIAL AFFAIRS? Yes

IS A SOCIAL WORK ASSESSMENT NECESSARY TO RENDER AN OPINION? No

PTSD REVIEW: EMPLOYMENT HISTORY

USUAL OCCUPATION:
Was employed in the finance area and sold mutual funds.

IS THE VETERAN CURRENTLY EMPLOYED? No

IS VETERAN RETIRED? No

IS VETERAN UNEMPLOYED BUT NOT RETIRED? Yes
REASON(S) GIVEN FOR UNEMPLOYMENT:
Has just returned from inpatient treatment and is desirous of finding gainful employment.
VETERAN CONTENDS UNEMPLOYMENT IS DUE TO THE MENTAL DISORDER'S EFFECTS: No

DOES THE VETERAN MEET THE DSM-IV CRITERIA FOR A DIAGNOSIS OF PTSD? Yes
AXIS I: PTSD, moderate
AXIS II: deferred
AXIS III: Hip pain; ankle pain
AXIS IV: Criminal legal proceedings; unemployment
AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING

SCORE: 50 TIME FRAME: Current functioning

PSYCH SUMMARY
=============

STATE PROGNOSIS FOR IMPROVEMENT OF PSYCHIATRIC CONDITION AND IMPAIRMENTS IN FUNCTIONAL STATUS:
Veteran experiences significant distress due to PTSD symptom configuration and will do well if he maintains therapeutic contact for individual, group, and pharmaceutical therapies.

WAS A MEDICAL OPINION REQUESTED? No

Signed by: /es/ THOMAS M COLLINS
PSYCHOLOGIST
12/14/2007 15:16

M224

IMMEDIATE MEMORY: Normal

PTSD SYMPTOMS

PERSISTENT RE-EXPERIENCING THE TRAUMATIC EVENT BY:
Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions, Recurrent distressing dreams of the event, Acting or feeling as if the traumatic event were recurring, Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event, Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

PERSISTENT AVOIDANCE OF STIMULI ASSOCIATED WITH THE TRAUMA AND NUMBING OF GENERAL RESPONSIVENESS:
Efforts to avoid thoughts, feelings, or conversations associated with the trauma, Efforts to avoid activities, places, or people that arouse recollections of the trauma, Markedly diminished interest or participation in significant activities, Feeling of detachment or estrangement from others

PERSISTENT SYMPTOMS OF INCREASED AROUSAL:
Difficulty falling or staying asleep

DESCRIPTION OF THE ONSET OF SYMPTOMS: Chronic

FREQUENCY, SEVERITY AND DURATION OF PTSD SYMPTOMS FOUND:
Multiple severe symptoms daily.

IDENTIFIED BEHAVIORAL, COGNITIVE, SOCIAL, AFFECTIVE, OR SOMATIC CHANGE THE VETERAN ATTRIBUTES TO STRESS EXPOSURE:
Veteran reports that symptoms began when he returned from Iraq but that he was in an environment as a drill instructor at Parris Island which helped him control the symptoms.

TESTS

QUANTITATIVE PSYCHOMETRIC ASSESSMENT OF PTSD SYMPTOM SEVERITY:
PTSD Checklist for Combat and Non-Combat Trauma, MMPI PTSD Subscales

PSYCHOMETRIC ASSESSMENT SCORES:
PCLM: 68
MMPI-2: High point scales 8-7-0-2, PK=39; 5 o 10 clinical scales elevated

STATEMENT AS TO WHETHER PSYCHOMETRIC SCORES ARE CONSISTENT WITH A DIAGNOSIS OF PTSD, BASED ON CUTTING SCORES/NORMATIVE DATA:
PCLM: raw score of 68 significantly above cutoff score; criteria met on B, C, and D
MMPI-2: Individuals with this profile are typically in a great deal of emotional turmoil marked by depression, pessimism, and inability to find comfort. They are usually not hesitant to admit psychological problems and tend to be worried, tense, and anxious. PK score is significantly elevated above the cutoff for the PTSD diagnosis.

DEGREE OF SEVERITY OF PTSD SYMPTOMS BASED ON PSYCHOMETRIC DATA: Severe

VALIDITY OF PSYCHOLOGICAL TEST RESULTS: Unclear
EXPLANATION OF TEST RESULTS:
Veteran is experiencing a great deal of distress at the present time given legal and psychiatric involvement in the last six months and potentially explain the reporting of high amounts of psychopathology.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Note

12/14/2007 08:00 ** CONTINUED FROM PREVIOUS PAGE **

Attention Intact
ABLE TO DO SERIAL 7'S? Yes
ABLE TO SPELL A WORD FORWARD AND BACKWARD? Yes

ORIENTATION:
INTACT TO PERSON: Yes

INTACT TO TIME: Yes

INTACT TO PLACE: Yes

THOUGHT PROCESS:
Unremarkable

THOUGHT CONTENT:
Ruminations

DELUSIONS:
None

JUDGMENT: Understands outcome of behavior

INTELLIGENCE: Average

INSIGHT: Patient partially understands that he/she has a problem.

DOES THE PATIENT HAVE SLEEP IMPAIRMENT? Yes
COMMENTS AND DESCRIPTION OF EXTENT SLEEP IMPAIRMENT INTERFERES WITH DAILY ACTIVITY:
Difficult failing asleep and staying asleep. Believes that the Ambien is winding him more than settling him down.

TYPE OF HALLUCINATIONS:
None

DOES THE PATIENT HAVE INAPPROPRIATE BEHAVIOR? No

INTERPRETS PROVERBS APPROPRIATELY? Yes

DOES THE PATIENT HAVE OBSESSIVE/RITUALISTIC BEHAVIOR? No

DOES THE PATIENT HAVE PANIC ATTACKS? Yes
FREQUENCY, SEVERITY, DURATION AND EFFECTS ON FUNCTIONING:
Veteran reports escalation in panic symptoms prior to entering inpatient PTSD program but has not experienced these symptoms since returning home.

IS THERE PRESENCE OF HOMICIDAL THOUGHTS? No

IS THERE PRESENCE OF SUICIDAL THOUGHTS? Yes
COMMENTS:
Prior to admission to PTSD inpatient program, he had ideation, plan, and means. He was going to go into the trees behind his house and place his .375 magnum pistol in his mouth and blow his head off.

EXTENT OF IMPULSE CONTROL: Fair

EPISODES OF VIOLENCE: No

ABILITY TO MAINTAIN MINIMUM PERSONAL HYGIENE? Yes

IS THERE PROBLEM WITH ACTIVITIES OF DAILY LIVING: No

MEMORY

REMOTE MEMORY: Normal
RECENT MEMORY: Normal
** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Notes

12/14/2007 08:00 ** CONTINUED FROM PREVIOUS PAGE **

PTSD REVIEW: POST MILITARY PSYCHOSOCIAL HISTORY

LEGAL HISTORY? Yes
COMMENTS AND DESCRIPTION OF LEGAL HISTORY:
Veteran acknowledges that he broke into a pharmacy in August 2007 to obtain pain medication. Spent 40 days in county prison before he was admitted to Coatesville VA

EDUCATIONAL ACCOMPLISHMENTS? No

DESCRIPTION OF MARITAL AND FAMILY RELATIONSHIPS:
Veteran describes a loving relationship with his wife and 3 children. His wife has told him recently that she is starting to see some of the same symptoms he was exhibiting before his latest hospitalization. Veteran acknowledges that he is becoming more irritated by his children and noise levels and believes that is he is being more punitive with them.

DESCRIPTION OF DEGREE AND QUALITY OF SOCIAL RELATIONSHIPS:
Veteran reports that he does not like to go out of the house much and that being away for close to three months on a pscyhiatric unit has cut him off from acquaintances.

DESCRIPTION OF ACTIVITIES AND LEISURE PURSUITS:
Restricted. Only spends time with wife and children. Plays video games and watches television when he can't sleep.

HISTORY OF SUICIDE ATTEMPTS? No

HISTORY OF VIOLENCE/ASSAULTIVENESS? No

SUMMARY STATEMENT OF CURRENT PSYCHOSOCIAL FUNCTIONAL STATUS:
Veteran has recently returned from an almost three month hospitalization at the VA PTSD inpatient program at Coatesville, PA, and has begun to slip back into preadmission status. PTSD symptoms have begun to escalate and affect his personal relationships.

ISSUES ASSOCIATED WITH ALCOHOL USE:
No problematic effect

ISSUES ASSOCIATED WITH OTHER SUBSTANCE USE:
Legal or other problematic consequences
DESCRIPTION OF LEGAL OR OTHER CONSEQUENCES:
Broke into pharmacy for pain medication. Case pending district attorney's decision about further prosecution.

PSYCH EXAM

GENERAL APPEARANCE:
Clean, Neatly groomed

PSYCHOMOTOR ACTIVITY:
Unremarkable

SPEECH:
Unremarkable

ATTITUDE TOWARD EXAMINER:
Cooperative, Guarded

AFFECT:
Constricted

MOOD:
Anxious, Depressed

ATTENTION:

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

NOTE DATED: 12/14/2007 08:00
LOCAL TITLE: WB COMPENSATION AND PENSION
STANDARD TITLE: C & P EXAMINATION NOTE
VISIT: 12/14/2007 08:00 ZZZCP PSYCH COLLINS
COMPENSATION AND PENSION EXAMINATION
REVIEW EVALUATION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

REVIEW OF RECORDS

C-FILE WAS:
Reviewed
MEDICAL RECORDS WERE:
Reviewed

MEDICAL HISTORY

PAST MEDICAL HISTORY

SIGNIFICANT NON-PSYCHIATRIC ILLNESSES, INJURIES, OR HOSPITALIZATIONS:
Hip pain; ankle pain

TREATMENT

WAS THERE OUTPATIENT TREATMENT FOR A MENTAL DISORDER? Yes
DATE(S) OF OUTPATIENT TREATMENT: Current
CONDITION(S) AND LOCATION OF TREATMENT:
PTSD - Psychology Group Therapy, Wilkes-Barre VA

HOSPITALIZATION(S)

WERE THERE ONE OR MORE HOSPITALIZATIONS FOR A MENTAL DISORDER? Yes
DATES OF HOSPITALIZATION(S): 09/25/2007-12/04/2007
CONDITION(S) AND LOCATION OF TREATMENT:
Coatesville VA PTSD inpatient program

PRESENT MEDICAL HISTORY

SYMPTOMS PRESENT DURING PAST YEAR: Yes
IS THERE CURRENT TREATMENT FOR A MENTAL DISORDER? Yes
SUMMARY OF CURRENT TREATMENT FOR MENTAL DISORDER:
Veteran has recently re-connected with VAMC-WB and will be seen for individual, group, and psychopharmacological intervention.
CURRENT TREATMENT(S): Anti-psychotic, Anti-depressant
SPECIFY MEDICATION AND OTHER COMMENTS: Effexor 37.5 mg. bid
Quetiapine 200 mg. h.s.
MEDICATION SIDE EFFECT(S): None
GROUP THERAPY: Yes
INDIVIDUAL PSYCHOTHERAPY: Yes
OTHER THERAPY: Individual therapy will begin with Dr. Matthew Dooley
at VAMC-WB
EFFECTIVENESS OF THERAPY: Poor
COMMENT ON EFFECTIVENESS OF THERAPY: Has only attended one group
session.
****

FREQUENCY, SEVERITY, AND DURATION OF NON-PTSD PSYCHIATRIC/MEDICAL SYMPTOMS:
Daily pain in hip and ankles is attentuated by pain medication.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

12/14/2007 10:00 ** CONTINUED FROM PREVIOUS PAGE **

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
12/17/2007 09:51

M229

MEDICAL RECORD — Progress Notes

NOTE DATED: 12/14/2007 10:00
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 12/14/2007 10:00 ZZZMHC LUCAS

Chief Complaint: Medication and symptom management

Subjective: "I've just returned from the Coatesville post-traumatic stress disorder program. I've been there for seventy days and was placed on some medication down there that I want to renew and place in my record up here. I have been using the venlafaxine at 37.5 mg. It was reduced because I'm on tramadol concurrently for pain. I also received tramadol 100 mg. three times a day and I get Ambien at night for sleep. The Ambien really isn't cutting it. I'm not able to sleep. It actually makes me feel like I'm more revved up and I don't use it that often. I do need to sleep because my sleep is disrupted. I'm up tossing and turning. I have had success with quetiapine in the past. It does put me to sleep, however, I get up in the morning with a little bit of a hangover and that part of it concerns me. It does help my racing thoughts slow down and does allow me to sleep restfully during the night. I have been doing well since I've been back. I do have charges pending for the break in to the pharmacy. I had been kind of addicted to the Vycodin and thought that would be the only place I could obtain them, if I break into a pharmacy. I know that this thinking was bizarre, but it was where I was at, at that time. I'm really sorry that happened, but it's something that I have to deal with. I am hooked up with Dr. Dooley for post-traumatic stress disorder counseling and I will be attending a group up in Scranton. My wife also attends a group in the Scranton counseling center and she is doing fairly well. I look forward to keeping things on an even keel from now on. I have no thoughts of hurting myself or anyone else."

Mental Status Examination: Patient is alert and oriented times three. Speech is relevant and coherent. He is casually dressed and well groomed. Eye contact is good. He is a walk-in today. Thoughts are organized; content is appropriate. Mood is neutral and affect is consistent. He denies any suicidal thought, intent or plan. Denies any homicidality. There are no audio or visual hallucinations. He does admit to some nightmares that awaken him during the night and keep his sleep disrupted. He is energized on Ambien. Judgment and insight are fairly good. No involuntary movements are noted. Has had success with quetiapine in the past. No psychomotor agitation or retardation.

Objective: Patient with nightmares, disrupted sleep. Side-effect of Ambien. No suicidality. No homicidality. Has legal stressors. No thought disorder or delusions. Just returned from Coatesville Post-traumatic stress disorder program for seventy days. He is goal directed.

Diagnosis: Post-traumatic stress disorder with depression

Plan: Continue venlafaxine at 75 mg. daily, order quetiapine 100 mg. at bedtime, take at 8:00 so he avoids a.m. hangover affect. Will reorder tramadol at 100 mg. three times a day due to his having this medication in Coatesville and he has no primary care provider at this time. D/C Ambien. Side-effects of the medication were discussed with the patient and he agrees to utilize the medicine. Encouraged to continue to attend support groups and take medications as ordered. Bring wife in to his next appointment so we can discuss his symptom picture and our treatment approach and allow her to be on the same page. Patient may call or come in if any side-effects, feels unsafe, has any questions or has new symptoms. Time of appointment was thirty minutes. Patient is satisfied. Return to clinic in two months.

D- 12/14/07 10:31
T- 12/16/07 12:55
T24
Job # 102864

M230 -

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Note

NOTE DATED: 12/14/2007 10:38
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 12/14/2007 10:00 ZZZMHC LUCAS
PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above.
Comment: quetiapine

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
12/14/2007 10:39

M231

MEDICAL RECORD — Progress Note

NOTE DATED: 12/20/2007 08:21
LOCAL TITLE: SCANNED C&P
STANDARD TITLE: SCANNED NOTE
VISIT: 12/20/2007 08:21 FILEROOM
see vista imaging

Signed by: /es/ RONALD T LOEFFLER
12/20/2007 08:22

M232

MEDICAL RECORD — Progress Note

NOTE DATED: 12/21/2007 13:30
LOCAL TITLE: PSYCHOLOGY GENERAL NOTE
STANDARD TITLE: PSYCHOLOGY NOTE
VISIT: 12/21/2007 13:30 PSYCH DOOLEY II

D: This was an initial 60-minute assessment/psychotherapy session with service connected veteran on his diagnosis of post-traumatic stress disorder. This session employed the use of diagnostic interview and ventilative procedures.

Discussed with veteran his recent discharge from inpatient post-traumatic stress disorder treatment. Interviewed veteran for apparent discontinuity between his symptom reports prior to that treatment. The veteran indicated that discontinuity was product of veteran minimizing severity of symptoms with mental health providers at the time.

The veteran indicates that he relays significant achievement of improved symptoms management while in Coatesville program. That he participated in psychoeducational trauma focus groups and individual trauma focused therapies, as well as achievement of improved emotional recognition skills. The veteran added that he feels he continues to have greater need for processing the memories of trauma. The veteran related that he had one inpatient substance abuse treatment approximately 10 years ago for Cocaine abuse. He denied any other history of mental health hospitalization. He states that he recently attended his first group psychotherapy session at The Scranton Veteran's Center for GWOT veteran and that the veteran has a process orientation.

The veteran identified improved affect management particularly anger management as a primary goal for this treatment. The veteran states that he currently lives with his parents (step mother and biological father) in addition to his wife and their children. The veteran states that there is ongoing discord between himself, his wife and the veteran's step mother. Processed relationship conflicts with veteran.

The veteran relayed interest in ventilative, problem solving oriented individual psychotherapy. Advised the veteran of availability of post-traumatic stress disorder services in this clinic to include wellness classes, returning home outreach activity, twelve week focused trauma recovery group and time-limited individual psychotherapy.

A: The veteran displayed mildly anxious mood with restricted affect. He denied and did not demonstrate current suicidal ideation, homicidal ideation, auditory or visual hallucination. His speech was logical, coherent and sequential but sometimes pressured. His insight and judgment seemed good.

DIAGNOSIS:

1. Post-traumatic stress disorder.

P: Continue individual outpatient assessment/psychotherapy with this veteran. Next session will include further diagnostic interviewing and follow up with veteran on his interest in participating in post-traumatic stress disorder programming available at this clinic. Current treatment plan includes veteran's attendance at wellness classes, returning home outreach activity and individual assessment/psychotherapy. Therapeutic goals are currently defined as improved anger management, affect regulation and relationship functioning.

D: 12/23/2007 12:58 PM
T: 12/24/2007 T28 105063

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
12/27/2007 10:58

M233

MEDICAL RECORD — Progress Notes

NOTE DATED: 12/28/2007 13:38
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 12/26/2007 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was "Family & Relationship Issues". Group began with a discussion of family/relationship dynamics and its typical responses to stress. An exploration of the challenges experienced by veterans and how that impacts the family/relationships they are in was discussed. Special emphasis was given to FX nature of SX of social isolation and its contribution to dysfunction. Instructed group on strategies to prevent and repair relationship damage including; communicating thoughts/feelings and mirroring to disarm defensiveness and prevent escalation. Practiced these techniques in session via A/V media and group interaction. Veteran seemed engaged and interactive.

A: Veteran displayed restricted affect congruent with mood. He did not report or demonstrate current SI/HI or A/V hallucinations. His insight and judgment seemed fair. His speech was logical, coherent and sequential.

DX: PTSD

P: Continue group therapy scheduled twice weekly for maintenance of coping abilities and reduction in MH symptoms.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
12/28/2007 13:38

M234

MEDICAL RECORD — Progress Note

NOTE DATED: 01/03/2008 10:17
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 01/02/2008 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was "PTSD & Substance abuse". Group began with a discussion of Post-Deployment Stress reactions and the role of substance abuse : the veterans' attempts to cope with their SXs. Alternative coping was explored via exercises designed to increase awareness of the connection between SXs, maladaptive coping and the effects of substance abuse in their lives. This veteran shared his difficulties with substance abuse, coping problems and their consequences. Veteran seemed engaged and interactive.

A: Veteran displayed restricted affect congruent with mood. He seemed alert and aware. He did not demonstrate SI/HI or A/V hallucinations. His insight and judgment seemed fair. His speech was logical, coherent and sequential. Veteran seemed engaged in TX.

DX: PTSD

P: Continue group therapy scheduled twice weekly for maintenance of coping abilities.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
01/22/2008 12:37

M235

MEDICAL RECORD Progress Note

NOTE DATED: 01/09/2008 09:23
LOCAL TITLE: NSG CLINICAL REMINDER NOTE
STANDARD TITLE: EDUCATION NOTE
VISIT: 01/09/2008 09:00 ZZZPATEL I PRICARE

Influenza Immunization:
Influenza Information
The patient refused administration of the influenza vaccine at this time.

NSG HEP C RISK ASSMT:
Patient has previously had Hepatitis C risk assessment.

NSG SPIRITUAL ASSMT:
Spiritual Assessment Questions:
Does your religious faith/spirituality provide comfort or does it cause you stress?
Comment: na
Does your religious faith/spirituality influence the way you think about your health; the medical decisions you make; or how you care for yourself?
Comment: No
Are you part of a religious/spiritual supportive community or congregation?
Comment: No
Are there any religious or spiritual issues that concern you?
Comment: No

Alcohol Screening (Nurse):
Yes
AUDIT C
An alcohol screening test (AUDIT-C) was positive (score=11).

1. How often did you have a drink containing alcohol in the past year? Four or more times a week

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? 10 or more

3. How often did you have six or more drinks on one occasion in the past year? Weekly

Provider informed of Positive Audit C Score.Relates quit drinking 8/07

Advance Directive:
Patient declines Advance Directive

NSG Weight Mgmt-BMI 25-29.9:

Most recent weight: 193 lb [87.7 kg] (01/09/2008 09:22)
Most recent height: 68 in [172.7 cm] (04/26/2007 14:06)
Calculated BMI: 29.4 BMI classification is OVERWEIGHT

--
It is recommended patients be screened yearly for overweight/obesity using BMI as the standard measure. BMI 25-29.9. Patient's BMI:
BODY MASS INDEX - JAN 09, 2008@09:22:32 29.4
Patient would NOT benefit from participation in a weight management program because of acute illness or injury, end-stage disease, moderate to severe cognitive impairments limiting ability to participate, or conditions for which weight loss may be contraindicated (anorexia, AIDS, terminal cancer).

Signed by: /es/ MILLER,JAYNE P.
lpn
01/09/2008 09:26

M236

MEDICAL RECORD Progress Note

01/09/2008 09:50 ** CONTINUED FROM PREVIOUS PAGE **

ABD: flat, soft, NABS +, nontender, no organomegaly/masses appareciated.
EXTS: warm, no edema/cyanosis/clubbing, good peripheral pulses
CNS: AAO x 3, no focal deficits noted.

LABS: reviewed.

INVESTIGATIONS:
*** Exam date: DEC 05, 2007@07:50 Proc: CHEST 2 VIEWS PA&LAT ***

*** IMPRESSION TEXT: ***

1. No active disease process is evident radiographically.

*** REPORT TEXT: ***
Findings: PA and lateral views are obtained. The lung fields are clear. The heart is not enlarged. Mild degenerative change noted within the thoracic spine.

A/P:
1. Right Hip Pain probblebursitis/?sciatica
   cont tramadol
   ortho referral consult pending
2. PTSD- adjustment disorder
   on trazodone quitiapine, venlafaxime, buspirone and clonazepalm
   follow up with psych
3. active smoker
   smoking cessation refused, risks and benefit explained in detail.

Patient was explained side effects of the medications, which he understood and verbalized. Plan of therapy was discussed with the patient, and he was agreeable.

Preventative - counselled regarding weight loss/exercise/smoking cessation/Diet
- Influenza Vaccine:refused

LABS: CBC w/diff, lipid profile, Chem profile - before next visit.
RTC: 6 months to Primary Care Clinic or early if necessary

PROVIDER Med Reconciliation:
Outpatient Medication Review
No change in current medication at this clinic visit.
PROVIDER TOBACCO COUNSELING FY07:
Patient is still a current user. Counseling done at this encounter.

1. ADVISED patient to quit tobacco.
2. ASSISTED patient to quit:
   a. Discussed the following strategies with patient to help with quitting:
      * Set a quit date, ideally within 2 weeks
      * Get support from family, friends and co-workers
      * Review past quit attempts-what helped, what led to relapse
      * Anticipate challenges, particularly during the first two weeks, including nicotine withdrawal
      * Identify reasons for quitting and benefits of quitting
   b. Offerred patient a referral to Stop Smoking Clinic.
   c. Offerred patient medication to assist with quitting

PROVIDER ALCOHOL SCR(+)<8:
Alcohol counseling given at this visit.
Level of Understanding: Good

Signed by: /es/ INDUBHAI M PATEL
STAFF PHYSICIAN PRIMARY CARE
01/09/2008 12:02

M237

MEDICAL RECORD Progress Note

NOTE DATED: 01/09/2008 09:50
LOCAL TITLE: MED PRIMARY CARE NOTE
STANDARD TITLE: PRIMARY CARE NOTE
VISIT: 01/09/2008 09:00 ZZZPATEL I PRICARE
CHIEF COMPLAIN: follow up on chronic medical problems.

HISTORY OF PRESENT ILLNESS: LASKOWSKI,STANLEY P III, is a 29 year old veteran came to my clinic today for a regular scheduled visit. pt is seen first time by me. He has PMHx of ajustment Disorder, Posttraumatic Stress Disorder, Skin Rashes, Right Hip Bursitis, Left Hip: Greater trochanteric bursitis, Right arm Fracture, Chronic Left Hip Pain, sinusitis, Right heel Spur, Hearing Loss and Tinnitus. The patient is having persistent problems, despite anti-inflammatory medication. The patient states he injured his forearm when he fell on stairs in 2002. He was placed in a cast for two weeks. He has Right plantar calcaneus spu from radiology report. Pt also had Admission for Concussion due to Motor Vehicl Accidentin 1994. Pt has rt hip pain motrin not helping now on tramadol which pt says is working for him, will refer to ortho for further evaluation. pt is active smoker smokes 1 ppd smoking cessation refused, risks and benefit explained in detail. denies any acute complain today.

Subjective: Denies any chest pain, shortness of breath, cough, fever, chills, headache, dizziness, palpitation, abdominal pain, diarrhea, constipation, melena, bright red blood per rectum, hematuria, urgency, dysuria, weakness, blurred vision, slurred speech, sensory loss or any other complaints.

Allergies: Patient has answered NKA
MEDICATIONS:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	BUSPIRONE 5 MG TABLET TAKE ONE TABLET BY MOUTH TWICE A DAY WITH MEALS	ACTIVE
2)	CLONAZEPAM 0.5MG TABLET TAKE ONE TABLET BY MOUTH DAILY AND TAKE TWO TABLETS AT BEDTIME	ACTIVE
3)	PAROXETINE 40 MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY DAY	ACTIVE
4)	QUETIAPINE 200MG TAB TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	ACTIVE
5)	TRAMADOL 50MG TAB TAKE TWO TABLETS BY MOUTH THREE TIMES A DAY UNTIL SEEN BY PRIMARY CARE	ACTIVE
6)	TRAZODONE 50MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME MAY START AT 1/2 TAB	ACTIVE
7)	VENLAFAXINE EXTENDED RELEASE 75MG CAPS TAKE ONE CAPSULE BY MOUTH DAILY WITH FOOD	ACTIVE

PMH:
Adjustment Disorder Unspecified
Posttraumatic Stress Disorder
Left Hip: Greater trochanteric bursitis.

SOCIAL: MARRIED LIVES WITH WIFE, 3 HEALTHY KIDS, 2 SON 1 DAUGHTER, SMOKES 1PPD FOR 12 YRS, QUIT ETOH IN AUG 2007, NO ILLICIT DRUGS
UNEMPLOYED NOW, WORKED AS FINANCIAL ADVISER

FAMILY HISTORY:
FATHER WITH HTN GOUT PVD, MOTHER DIED AT THE AGE OF 45 POSSIBLE DRUG OVERDOSE

OBJECTIVE:
VITAL SIGNS: T 98.8 F [37.1 C] (04/26/2007 14:06), R 20 (01/09/2008 09:22), P 88 (01/09/2008 09:22), BP 121/77 (01/09/2008 09:22)
PULSE OXIMETRY - NONE FOUND - 2Y
GENERAL: old male, alert and oriented, afebrile, comfortable, not in any distress.
SKIN: no jaundice, no pallor, no cyanosis, dry, non-scaly
HEENT: NCAT, anicteric sclerae, pink conjunctiva, PERRLA, moist oral mucosa.
NECK: supple, no JVD, no carotid bruit, no lymphadenopathy/ thyromegaly.
CHEST: Symmetrical, nontender.
LUNGS: Clear bilatereally, no rales/wheezes
HEART: s1 s2, regular, no murmur/gallop.

** THIS NOTE CONTINUED ON NEXT PAGE **

M238

MEDICAL RECORD Progress Not

NOTE DATED: 01/10/2008 16:08
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 01/10/2008 16:02 TLCP PSYCHIATRY
Patient with difficulty sleeping wants Ambien, stays asleep too long with Quetiapine. Wants a different antidepressant, maybe Cymbalta. Remeron works to initiate sleep in the PM. Will decrease Quetiapine to 50mg at HS, increase Mirtazapine to 22.5mg at HS and add multivitamin daily. We will discuss other changes at his appointment on 1/29. Patient satisfied.

Signed by: /es/ Eugene T. Lucas Jr.
CRNP Psych Mental Health-BC
01/10/2008 16:13

M239

MEDICAL RECORD Progress Note

NOTE DATED: 01/14/2008 10:38
LOCAL TITLE: TLCP OIF/OEF
STANDARD TITLE: OEF/OIF TELEPHONE ENCOUNTER NOTE
VISIT: 01/14/2008 10:38 TLCP OIF/OEF
Data: Spoke with veteran this am. Vet requesting to f/u with a Psychiatrist and not a physician assistant. I contacted MHC to ascertain if this was possible and was informed it was. Vet stated he was available any day but Tuesdays; however, the next available appt was on 2/12 (Tuesday). In addition, there was an avilable appt on 2/13 but because it was more than 30 days in advance - this can not be made until tomorrow. I contacted vet and tolf him I would make the appt for him tomorrow and then call him back with the appt time, vet appreciative.

Signed by: /es/ SANDRA DOMPKOSKY RN MSN
OIF/OEF RN Case Manager
01/14/2008 10:42

01/15/2008 10:12 ADDENDUM STATUS: COMPLETED
Data: Appt was made with Dr. Bhatia on 2/4/08 @ 9am & the 1/29 appt was cancelled. I left a voicemail message for veteran with above info and requested a return call confirmation of same.
Signed by: /es/ SANDRA DOMPKOSKY RN MSN
OIF/OEF RN Case Manager
01/15/2008 10:13

01/16/2008 10:15 ADDENDUM STATUS: COMPLETED
Data: Return call rcvd from vet stating new appt date & time was good.
Signed by: /es/ SANDRA DOMPKOSKY RN MSN
OIF/OEF RN Case Manager
01/16/2008 10:15

M240

MEDICAL RECORD Progress Note

NOTE DATED: 01/17/2008 16:20
LOCAL TITLE: PSYCHOLOGY GENERAL NOTE
STANDARD TITLE: PSYCHOLOGY NOTE
VISIT: 01/17/2008 16:20 PSYCH DOOLEY II

D: The veteran attended 50 minute psychotherapy/assessment session on his service connected diagnosis of post-traumatic stress disorder employing diagnostic and motivational interviewing interventions. The veteran began session by relaying that he continues to attend GWOT psychotherapy group at Scranton Veterans Center. The veteran inquired regarding process oriented groups and his expectations. The veteran relays satisfaction with attendance at wellness classes and inclusion of his wife at relevant classes. He also indicates some improvement in family discord and his management of subsequent stress. Processed with veteran family discord issues for maladaptive cognitions.

Introduced veteran to cognitive restructuring and discussed with veteran availability of 12 week trauma focused time-limited cognitive processing therapy group to further address his symptom complaints. Provided veteran with information on the group and recommendation that he attend. The veteran expressed understanding and agreement with this recommendation.

Advised the veteran that there does not appear to be acute need for veteran's individual psychotherapy at this time and further advised him to continue attending wellness classes and that writer will notify veteran when next available CPT group treatment will begin. Advised veteran to contact writer should individual contact become necessary. The veteran expressed understanding and agreement.

A: The veteran displayed mildly anxious mood with restricted affect. He denied and did not demonstrate current suicidal ideation, homicidal ideation, auditory or visual hallucination. His speech was logical, coherent and sequential. His insight seemed fair with good judgment.

DIAGNOSIS: Post-traumatic stress disorder.

P: Discontinue individual outpatient psychotherapy. Treatment plan will proceed with veteran's continuing attendance at wellness classes to improve symptom insight and coping skills and eventual inclusion in time-limited CPT group psychotherapy to improve his recovery from post-traumatic stress disorder symptoms. The veteran will be notified at next available beginning date for that group.

D: 01/18/2008 3:27 PM
T: 01/19/2008 T28 111798

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
02/17/2008 09:34

M241

[redacted] WILKES-BARRE VAMC Printed:06/29/2009 15:34
Pt Loc: OUTPATIENT Vice SF 509

MEDICAL RECORD Progress Note

NOTE DATED: 01/18/2008 14:55
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 01/16/2008 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was "Battle Mind". Group began with a discussion of the effects of military training and combat experiences upon the veteran's psychological functioning, as an adaptive change that maximizes survival in that context. Explored contrast between Battle Mind Fx in combat an problems it causes in psychological and relational Fx, when applied in civilian contexts. Provided instruction on how to identify when Battle Mind may be undermining civilian FX and how to intervene.

This veteran shared some of the experience of his symptoms and their impact upor his FX.

A: Veteran displayed restricted affect congruent with mood. He seemed alert and aware. He did not demonstrate SI/HI or A/V hallucinations. His insight and judgment seemed fair. His speech was logical, coherent and sequential. Veteran seemed engaged in TX.

DX: PTSD

P: Continue group therapy scheduled twice weekly for maintenance/improvement of coping abilities.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
01/18/2008 14:55

M242

[redacted] WILKES-BARRE VAMC Printed:06/29/2009 15:34
Pt Loc: OUTPATIENT Vice SF 509

MEDICAL RECORD — Progress Notes

NOTE DATED: 01/23/2008 08:00
LOCAL TITLE: SCANNED FEE BASIS
STANDARD TITLE: SCANNED NOTE
VISIT: 01/30/2008 08:00 FILEROOM
Please refer to the scanned text document attached. This can be accessed by selecting Imaging and then Display from the Tools Menu.

Signed by: /es/ THOMAS V MUNLEY
01/30/2008 08:01

M243

MEDICAL RECORD — Progress Notes

NOTE DATED: 01/29/2008 19:28
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 01/23/2008 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was "Coping Skills". Group began with a discussion of emotional and thinking systems and how they are effected by stress. Instructed group on physiological correlates of emotions, effect upon thinking, purpose of emotions and techniques for identifying emotional states. Practiced these techniques with group and provided members resources to take with them to continue practice at home. This veteran shared personal difficulties managing affect and its consequences.

A: Veteran displayed restricted affect congruent with mood. Veteran seemed alert and aware. Veteran did not demonstrate SI/HI or A/V hallucinations. Veteran's insight and judgment seemed fair. Veteran's speech was logical, coherent and sequential. Veteran seemed engaged in TX.

DX: PTSD

P: Continue group therapy scheduled twice weekly for maintenance/improvement of coping abilities.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
01/29/2008 19:28

M244

MEDICAL RECORD

NOTE DATED: 01/31/2008 10:18
LOCAL TITLE: PSYCHOLOGY GROUP THERAPY
STANDARD TITLE: PSYCHOLOGY GROUP COUNSELING NOTE
VISIT: 01/30/2008 18:30 ZZZPCT GROUP PM
D: Veteran participated in 60-minute group psychotherapy for SC condition. The group topic for this meeting was Relaxation Strategies. Group began with a discussion of the contrasting effects of stress and relaxation responses upon physiological, emotional and cognitive systems. Instructed group in relaxation techniques focused upon areas of thought, body, and emotions. Performed techniques with group. Provided veterans with printed instructions of techniques. Advised group to practice these techniques at home in order to strengthen their usefulness in coping.

A: Veteran displayed restricted affect congruent with mood. He seemed alert and aware. He did not demonstrate/report current SI/HI or A/V hallucinations. His insight and judgment seemed fair. His speech was logical, coherent and sequential. Veteran seemed engaged in TX.

DX: ptsd

P: Continue group therapy scheduled twice weekly for maintenance/improvement of coping skills.

Signed by: /es/ MATTHEW DOOLEY
STAFF PSYCHOLOGIST BEHAVIORAL SVCS
04/21/2008 18:36

M245

LASKOWSKI,STANLEY R III [redacted]

WILKES-BARRE VAMC
Pt Loc: OUTPATIENT

Printed:06/29/2009 15:34
Vice SF 509

M246

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/04/2008 09:25
LOCAL TITLE: PROVIDER MEDICATION RECONCILIATION NOTE
STANDARD TITLE: E & M NOTE
VISIT: 02/04/2008 09:00 MHC BHATIA CMI
PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Comment: Prozac
A medication is to be discontinued during medication profile review at this clinic visit. See Plan of Care above. Patient verbalizes understanding of discontinuation of medication(s).
Comment: Seroquel, Effexor XR, Paxil, Remeron, Desyrel, Buspar

AIMS:
AIMS (Mental Health Instrument)
The patient was evaluated for symptoms of tardive dyskinesia using the AIMS.
Total score for items 1-7: 0

1. Complete Examination Procedure before making ratings.
MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one LESS than those observed spontaneously. Facial and Oral Movements Muscles of facial expression, e.g., movements of forehead, eyebrows, periorbital area, cheeks. Include frowning, blinking, grimacing of upper face: None

2. Facial and Oral Movements Lips and perioral area, e.g., puckering, pouting, smacking: None

3. Facial and Oral Movements Jaw, e.g., biting, clenching, chewing, mouth opening, lateral movement: None

4. Facial and Oral Movements Tongue. Rate only increase in movement both in and out of mouth, not inability to sustain movement: None

5. Extremity Movements Upper (arms, wrists, hands, fingers). Include movements that are choreic (rapid, objectively purposeless, Irregular, spontaneous) or athetoid (slow, irregular, complex, serpentine). Do not include tremor (repetitive, regular, rhythmic movements): None

6. Extremity Movements Lower (legs, knees, ankles, toes), e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, Inversion and eversion of foot: None

7. Trunk Movements Neck, shoulders, hips, e.g., rocking, twisting, squirming, pelvic gyrations. Include diaphragmatic movements: None

8. Global Judgments Severity of abnormal movements: none, normal

9. Global Judgments Incapacitation due to abnormal movements: none, normal

10. Global Judgments Patient's awareness of abnormal movements. Rate only patient's report: no awareness

11. Dental Status Current problems with teeth and/or dentures: no

12. Dental Status Does patient usually wear dentures? no

Tobacco Use Screen:
Patient is a current smoker.

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
02/04/2008 09:29

M247

MEDICAL RECORD

NOTE DATED: 02/04/2008 09:40
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 02/04/2008 09:00 MHC BHATIA CMI
SUBJECT: phe

Patient came in for an outpatient follow up visit. He had previously been seen in the walk-in clinic and also has completed a 70-day program for posttraumatic stress disorder at the Coatesville VA Medical Center. He has been having trouble with his medications and has been on several of them including, Seroquel - which makes him extremely drowsy, Buspar - which has been completely ineffective, Remeron - which also made him very sedated, trazodone - which was substituted for Ambien CR at the Coatesville VA Medical Center but which did not help him to any significant extent, Wellbutrin - which increased his anxiety and irritability, Paxil - which also increased his irritability and anxiety and, currently Effexor XR 75 mg daily - which he feels has been making him somewhat unmotivated with feelings of passivity and fatigue. Patient had been on a higher dose of Effexor XR but stated that the feelings of anergy had increased during that time. He feels extremely unhappy about this since he does wish to contribute towards taking care of his family. He does attend group therapy sessions both at this facility as well as at the Scranton Veteran Center. Patient was also receptive to psychotherapy during this session and agreed to work on setting a more structured daily routine for himself. He is also willing to switch from Effexor XR to a different antidepressant at this time. It was decided to try Prozac. Patient was educated on the potential benefits and side effects of this medication. He is agreeable to giving it a trial.

MENTAL STATUS EXAMINATION: Patient is awake, alert, and oriented to person, place, and time. He is somewhat anxious but not irritable. He was quite pleasant, cooperative, and verbal. He denies suicidal or homicidal ideation but does admit to feeling rather depressed and unmotivated. Patient is coherent, relevant, and goal directed. He has fair memory, concentration, and attention span. He also displayed fair judgment and insight.

ASSESSMENT: POSTTRAUMATIC STRESS DISORDER.

PLAN: Patient's Effexor XR will be discontinued at this time. He will be started on Prozac 20 mg p.o. q.a.m. He will continue to attend group therapy sessions on a regular basis. He will return for further followup within the next 4-6 weeks.

AB/OSi/227551/0/02/04/2008 09:50:24/kt/D:02/04/2008
09:43:51/T:02/04/2008
09:50:24/VAJob#:1106969/IChartJob#28631077/22734803

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
02/04/2008 11:09

M248

MEDICAL RECORD

NOTE DATED: 02/08/2008 11:06
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 02/08/2008 11:06 TLCP PSYCHIATRY
Received message from pt stating that he has been tolerating his Prozac quite well and would like to continue on it.

P: Continue Prozac 20mg po q am.

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
02/08/2008 11:10

M249

MEDICAL RECORD

NOTE DATED: 02/11/2008 10:53
LOCAL TITLE: TLCP PSYCHIATRY
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 02/11/2008 10:52 TLCP PSYCHIATRY
Received call from pt stating that he has increased the dosage of Prozac on his own and has found that it has improved both his mood and his energy levels dramatically. He has also implemented a more structured daily routine for himself and feels very proud of the same.

P: Increase Prozac 20mg po bid as pt prefers this dosing. F/U next month.

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
02/11/2008 10:58

M250

02/15/2008 09:18 ** CONTINUED FROM PREVIOUS PAGE **

Potential barriers to reporting pain and/or using analgesics:

Other:

What is your pain goal? (from 0-10)
0

Interventions:
Patient referred to physician in outpatient

Signed by: /es/ MARY J FILIPKOWSKI
RN BSN
02/15/2008 09:22

02/15/2008 10:12 ADDENDUM STATUS: COMPLETED
TORADOL 60MG IM IN THE LEFT GLUTEAL MUSCLE AT 10:05AM.
Signed by: /es/ CHARMAINE KUJAWSKI
RN
02/15/2008 10:12

02/15/2008 10:47 ADDENDUM STATUS: COMPLETED
pt states he had no relief from the Toradol injection. pt requesting percocets.
will be referred to his PCP. d/c'ed home.
Signed by: /es/ BRENDA J MCGLYNN
RN
02/15/2008 10:48

M251

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 09:18
LOCAL TITLE: NSG TRIAGE
STANDARD TITLE: NURSING TRIAGE NOTE
VISIT: 02/15/2008 09:13 TRIAGE-BASEMENT
TRIAGE (UNSCHEDULED): NON-URGENT

ALLERGY: Patient has answered NKA

LATEX ALLERGY: NO
Patient states he is also allergic to:

Do you feel safe in your home environment? Yes

Active Outpatient Medications (including Supplies):

FLUOXETINE 20 MG CAP TAKE ONE CAPSULE BY MOUTH TWICE A DAY ACTIVE
WITH MEALS
MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY ACTIVE
TRAMADOL 50MG TAB TAKE TWO TABLETS BY MOUTH THREE TIMES A ACTIVE
DAY AS NEEDED AS NEEDED FOR PAIN

T: 97.1 F [36.2 C] (02/15/2008 09:17)
P: 85 (02/15/2008 09:17)
R: 18 (02/15/2008 09:17)
BP: 137/87 (02/15/2008 09:17)
PAIN: 10 (02/15/2008 09:17)
PULSE OXIMETRY:

MODE OF ARRIVAL: AMBULANT

DATA: C/o sharp pain in rt. scapula area after cleaning off his car yesterday.

ASSESSMENT: Pain increases with movemnt of lt. arm.

PLAN: er md

PAIN ASSESSMENT

Do you have pain?yes If yes, choose a number from 0 to 10 that best describes your pain
10

If the patient answers yes, complete the following assessment:

Where is the location (or locations) of your pain?
rt. scapular area

Describe what your pain feels like?
Sharp
When did the pain start?yesterday

Is the pain always there or does it come and go?
Pain always there
What makes the pain worse?movment of lt. arm

What makes the pain better?n/a

Does the pain affect the following activities?

Other:

Present medications or treatments used for pain and their effectiveness:
(Include VA, non-VA, and store bought):Tramadol, Naprosyn

Over-the-counter meds:

M252

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 09:22
LOCAL TITLE: ER ATTENDING NOTE
STANDARD TITLE: EMERGENCY DEPT NOTE
VISIT: 02/15/2008 09:22 ER (AM) CLINIC
Subjective: Patient is a 30-year-old male with a past medical history of post-traumatic stress disorder, chronic left hip pain, and also right shoulder pain, who came to the emergency room with the chief complaint of pain over the right scapular area since yesterday. As per patient, he has chronic on and off pain over that area, but after he was cleaning his car yesterday his pain got worse so he came to the emergency room. He denies any fall or recent injury to that area.

On physical examination, alert, awake, not in any distress.
VITAL SIGNS: Temperature 97.1, pulse 85, respirations 18, blood pressure 137/87.
HEENT EXAMINATION: Unremarkable.
NECK: Supple, no jugular venous distention or hepatojugular reflux.
HEART: S1 and S2 regular.
LUNGS: Clear.
ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds.
EXTREMITIES: Right shoulder: Reproducible tenderness over the right scapular area. Limited range of motion secondary to pain. Normal pulses.

Assessment:

1. Acute on chronic right shoulder pain.
2. Post-traumatic stress disorder.

Plan:

1. Patient was given intramuscular Toradol 60 mg. in the emergency room and his pain partially improved.

2. Patient was prescribed Medrol dose pack.

3. Advised him to continue his tramadol, but he stated that he wants a refill for Percocet because tramadol is not working. I advised him that we cannot authorize a refill for Percocet in the emergency room and he stated that only that medication works. I referred the patient to his PCP for evaluation and further refill of his narcotic medication.

d- 2/16/08 7:43 a.m.
J# 120021 TA12

Signed by: /es/ KAMLESH R PATEL
STAFF PHYSICIAN MEDICAL SERVICE
02/19/2008 08:30

Receipt Acknowledged By: /es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
02/19/2008 08:44

M253

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 10:12
LOCAL TITLE: 1010M ER/SPU CLINICIAN DISCHARGE INSTRUCTIONS(CHILD)
STANDARD TITLE: PHYSICIAN DISCHARGE NOTE
VISIT: 02/15/2008 09:22 ER (AM) CLINIC
Clinician Discharge Instructions:
Instructions

Discharge Instructions were given to LASKOWSKI,STANLEY P III on FEB 15, 2008.

Mode of Departure: Ambulatory

** FUTURE APPOINTMENTS **
DATE/TIME CLINIC (LOCATION)

Aftercare sheet given: Yes.

Discharge dietary instructions: LOW CHOLESTROL DIET

Follow-up activity/limitations: Restrictions: NO HEAVY LIFTING, PUSHING OR PULLING.

Condition: Satisfactory

What to do if symptoms worsen: RETURN TO EMERGENCY ROOM IF PAIN WORSENS.

Patient Instructions:

TAKE MEDROL DOSE PACK AS DIRECTED.
CONTINUE TRAMDOL AND NAPROXEN AS PRESCRIBED BY PCP.
ONLY TAKE YOUR MEDICATIONS AS DIRECTED.
DO NOT TAKE EXTRA MEDICATION.
REST RIGHT SHOULDER.
MOIST HEAT TO RIGHT SHOULDER.
GENTLE NECK AND SHOULDER EXERCISES.
NO HEAVY LIFTING, PUSHING OR PULLING.
FOLLOW UP WTIH PRIMARY CARE PHYSICIAN.

Patient/or patient's representative verbalizes understanding.

PLEASE NOTE: A copy of your ER visit can be made available upon request thru the office of Release of Information.

Patient

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS:

DATE

SIGNATURE OF PATIENT

Signed by: /es/ PAULA ARIAS
PA-C
02/15/2008 10:20

02/15/2008 10:48 ADDENDUM STATUS: COMPLETED
PT STATES HE IS IN SEVERE PAIN AND CANNOT TOLERATE IT. PATIENT REQUESTING DIFFERENT PAIN MEDICATION FOR HIS PAIN. HE IS BEING REFERRED TO HIS PCP FOR 1PM APPT TODAY. APPT WAS MADE FOR HIM.
Signed by: /es/ PAULA ARIAS
PA-C
02/15/2008 10:50

M254

MEDICAL RECORD

NOTE DATED: 02/15/2008 10:21
LOCAL TITLE: SCANNED CONTINUING MEDICATION RECORD
STANDARD TITLE: SCANNED NOTE
VISIT: 02/15/2008 09:22 ER (AM) CLINIC
LASKOWSKI,STANLEY P III, a 30 year old MALE, seen for reconciliation of medications.

ALLERGIES/ADR: Patient has answered NKA

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	FLUOXETINE 20 MG CAP TAKE ONE CAPSULE BY MOUTH TWICE A DAY WITH MEALS	ACTIVE
2)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
3)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
4)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE
5)	TRAMADOL 50MG TAB TAKE TWO TABLETS BY MOUTH THREE TIMES A DAY AS NEEDED AS NEEDED FOR PAIN	ACTIVE

Changes in medications (list medications):
SEE NOTE

Signed by: /es/ PAULA ARIAS
PA-C
02/15/2008 10:22

M255

MEDICAL RECORD

NOTE DATED: 02/15/2008 13:28
LOCAL TITLE: NSG CLINICAL REMINDER NOTE
STANDARD TITLE: EDUCATION NOTE
VISIT: 02/15/2008 13:00 ZZZPATEL I PRICARE
Influenza Immunization:
Influenza Information
The patient refused administration of the influenza vaccine at this time.

Tobacco Use Screen:
Patient is a current smoker.
Patient has history of smoking.
Smoking cessation education refused.
Patient had tobacco use screen exam at this encounter.
SMOKING CESSATION QUESTIONS
Does patient smoke?
Yes
Was patient advised to stop smoking? Yes
Were benefits of smoking cessation explained to patient? Yes
Level of understanding: Good
Is patient interested in smoking cessation classes? No

NSG DEPRESSION SCREEN:
Screen: Over the past two weeks, how often have you been bothered by the following problems?
1. Little interest or pleasure in doing things
More than half the days(Score=2)
2. Feeling down, depressed, or hopeless
More than half the days(Score=2)
PHQ-2 Depression screen was positive with a PHQ score of 4
DENIES SUICIDAL INTENTIONS
DR.I.PATEL NOTIFIED

Signed by: /es/ CYNTHIA SNYDER
RN STAFF NURSE PRIMARY CARE
02/15/2008 13:38

M256

Progress Notes

MEDICAL RECORD

02/15/2008 13:37 ** CONTINUED FROM PREVIOUS PAGE **

*** IMPRESSION TEXT: ***

1. No active disease process is evident radiographically.

*** REPORT TEXT: ***
Findings: PA and lateral views are obtained. The lung fields are clear. The heart is not enlarged. Mild degenerative change noted within the thoracic spine.

A/P:
trigger point in rhomboid region appear to be consistent with strained muscle
tylenol # 3 every 6 hr prn pain also advised for rest, apply capsain cream as well as to use heating pad.
follow up with ortho as schedule

Patient was explained side effects of the medications, which he understood and verbalized. Plan of therapy was discussed with the patient, and he was agreeable.

Preventative - counselled regarding weight loss/exercise/smoking cessation/Diet

LABS: CBC w/diff, lipid profile, Chem profile - before next visit.
RTC: 3 months to Primary Care Clinic or early if necessary

PROVIDER POSITIVE DEP SCR F/U:
PHQ-9 Depression screen:
Scoring: 0 = Not at all; 1 = Several days; 3 = Nearly every day
2 = More than half the days;

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	0
2. Feeling down, depressed, or hopeless	0
3. Trouble falling/staying asleep sleeping too much	0
4. Feeling tired or having little energy	0
5. Poor appetite or overeating	0
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0
7. Trouble concentrating on things, such as reading the newspaper or watching television	0
8. Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0
9. Thoughts that you would be better off dead or of hurting yourself in some way	0

Total score = 0

PROVIDER Med Reconciliation:
Outpatient Medication Review
tylenol # 3 and capsaicin cream added, tramdol discontunued

Signed by: /es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
02/15/2008 15:37

M257

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 13:37
LOCAL TITLE: MED PRIMARY CARE NOTE
STANDARD TITLE: PRIMARY CARE NOTE
VISIT: 02/15/2008 13:00 ZZZPATEL I PRICARE
CHIEF COMPLAIN: follow up after recent ER visit.

HISTORY OF PRESENT ILLNESS: LASKOWSKI,STANLEY P III, is a 30 year old veteran came to my clinic today for a regular scheduled visit. He has PMHx of ajustment Disorder, Posttraumatic Stress Disorder, Skin Rashes, Right Hip Bursitis, Left Hip: Greater trochanteric bursitis, Right arm Fracture, Chronic Left Hip Pain, sinusitis, Right heel Spur, Hearing Loss and Tinnitus. The patient is having persistent problems, despite anti-inflammatory medication. The patient states he injured his forearm when he fell on stairs in 2002. He was placed in a cast for two weeks. He has Right plantar calcaneus spur from radiology report. Pt also had Admission for Concussion due to Motor Vehicle Accidentin 1994. Pt has rt hip pain motrin not helping now on tramadol which pt says is working for him, pt is active smoker smokes 1 ppd smoking cessation refused, risks and benefit explained in detail. pt is seen by otho on jan 13, 2008 for detail see scan document. pt was seen in ER today with c/o sharp pain in rt.scapula area after cleaning off his car yesterday, pt was recently seen by ortho and he has trigger point in rhomboid region appear to be consistent with strained muscle asking me for another pain killer, tylenol # 3 every 6 hr prn pain also advised to apply capsain cream as well as to use heating pad, physical therapy as advised by ortho.

Subjective: Denies any chest pain, shortness of breath, cough, fever, chills, headache, dizziness, palpitation, abdominal pain, diarrhea, constipation, melena, bright red blood per rectum, hematuria, urgency, dysuria, weakness, blurred vision, slurred speech, sensory loss.

Allergies: Patient has answered NKA
MEDICATIONS:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE
3)	FLUOXETINE 20 MG CAP TAKE ONE CAPSULE BY MOUTH TWICE A DAY WITH MEALS	ACTIVE
4)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
5)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
6)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE

PMH:
Posttraumatic Stress Disorder (ICD-9-CM Hip Pain
OBJECTIVE:
VITALS: T-97.1 F [36.2 C] (02/15/2008 09:17), P-85 (02/15/2008 09:17), RR- 18 (02/15/2008 09:17), BP-137/87 (02/15/2008 09:17)
GENERAL: alert and oriented, afebrile, comfortable, not in any distress.
SKIN: no jaundice, no pallor, no cyanosis, dry, non-scaly
HEENT: NCAT, anicteric sclerae, pink conjunctiva, PERRLA, moist oral mucosa.
NECK: supple, no JVD, no carotid bruit, no lymphadenopathy/ thyromegaly.
CHEST: Symmetrical, nontender.
LUNGS: Clear bilatereally, no rales/wheezes
HEART: s1 s2, regular, no murmur/gallop.
ABD: flat, soft, NABS +, nontender, no organomegaly/masses appareciated.
EXTS: warm, no edema/cyanosis/clubbing, good peripheral pulses
CNS: AAO x 3, no focal deficits noted.

LABS: reviewed.

INVESTIGATIONS:
*** Exam date: DEC 05, 2007@07:50 Proc: CHEST 2 VIEWS PA&LAT ***

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 23:29
LOCAL TITLE: 1010M CLINICIAN ER USE ONLY(CHILD)
STANDARD TITLE: OUTPATIENT E & M INTERDISCIPLINARY NOTE
VISIT: 02/15/2008 09:22 ER (AM) CLINIC
1010m Clinician Entry (ER USE ONLY)
ER NOTE DICTATED.

Signed by: /es/ KAMLESH R PATEL
STAFF PHYSICIAN MEDICAL SERVICE
02/15/2008 23:30

M259

Progress Notes

MEDICAL RECORD

NOTE DATED: 02/15/2008 23:30
LOCAL TITLE: PROVIDER MEDICATION RECONCILIATION NOTE
STANDARD TITLE: E & M NOTE
VISIT: 02/15/2008 09:22 ER (AM) CLINIC
LASKOWSKI,STANLEY P III, a 30 year old MALE, seen for reconciliation of medications.

ALLERGIES/ADR: Patient has answered NKA

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE
3)	FLUOXETINE 20 MG CAP TAKE ONE CAPSULE BY MOUTH TWICE A DAY WITH MEALS	ACTIVE
4)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
5)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
6)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE

Changes in medications (list medications):
SEE NOTE.

Signed by: /es/ KAMLESH R PATEL
STAFF PHYSICIAN MEDICAL SERVICE
02/15/2008 23:30

M260

Progress Notes

EDICAL RECORD

OTE DATED: 02/16/2008 07:47
OCAL TITLE: 1010M CLINICIAN ER USE ONLY(CHILD)
TANDARD TITLE: OUTPATIENT E & M INTERDISCIPLINARY NOTE
ISIT: 02/15/2008 09:22 ER (AM) CLINIC
010m Clinician Entry (ER USE ONLY)
R NOTE DICTATED.

Signed by: /es/ KAMLESH R PATEL
STAFF PHYSICIAN MEDICAL SERVICE
02/16/2008 07:47

M261

MEDICAL RECORD
03/02/2008 12:21 ** CONTINUED FROM PREVIOUS PAGE **

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS:

SIGNATURE OF PATIENT DATE

Signed by: /es/ WILLIAM R. RICE, PA-C
Physician Assistant
03/02/2008 12:26

<< Interdisciplinary Note - End >>

M262

Progress Notes

MEDICAL RECORD

03/02/2008 12:16 ** CONTINUED FROM PREVIOUS PAGE **

Accessment & Plan:1. DX cervical Sprain/Strain, soft cervical collar applied, darvocet, Flexeril as ordered. RICE TX, F/U FMD in 1 or 2 days.

PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Comment: Flexeril 10mg po q8hrs/prn, Darvocet 1 tablet every 4-6 hrs Prn

Signed by: /es/ WILLIAM R. RICE, PA-C
Physician Assistant
03/02/2008 12:21

Receipt Acknowledged By: /es/ HOWARD J COX
ATTENDING PHYSICIAN, MEDICAL SERVICE
03/02/2008 12:41

<< Interdisciplinary Note - Cont. >>
ENTRY DATED: 03/02/2008 12:21
LOCAL TITLE: 1010M ER/SPU CLINICIAN DISCHARGE INSTRUCTIONS(CHILD)
STANDARD TITLE: PHYSICIAN DISCHARGE NOTE
VISIT: 03/02/2008 10:51 ER (AM) CLINIC
Clinician Discharge Instructions:
Instructions

Discharge Instructions were given to LASKOWSKI,STANLEY P III on MAR 02, 2008.

Mode of Departure: Ambulatory

3 ** FUTURE APPOINTMENTS **
DATE/TIME CLINIC (LOCATION)
MAR 7,2008@14:00 PT-AMS/2ND FLR SILVER ARE (2ND FLR ROOM C2-17)

Aftercare sheet given: Yes.

Discharge dietary instructions: as tolerated

Follow-up activity/limitations: Restrictions (specify)No lifting more than 10 lbs, wear collar until you see you PCP.

Condition: Unchanged

What to do if symptoms worsen: (specify) return to ER Dept, see FMD

Patient Instructions: Rest, Ice, Soft cervical collar, flexeril, darvocet as noted on label.

Patient/or patient's representative verbalizes understanding.

PLEASE NOTE: A copy of your ER visit can be made available upon request thru the office of Release of Information.

M263

Patient

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD

<< Interdisciplinary Note - Cont. >>
ENTRY DATED: 03/02/2008 12:16
LOCAL TITLE: 1010M CLINICIAN ER USE ONLY(CHILD)
STANDARD TITLE: OUTPATIENT E & M INTERDISCIPLINARY NOTE
VISIT: 03/02/2008 10:51 ER (AM) CLINIC
1010m Clinician Entry (ER USE ONLY)

CC: I have pain in my neck

HPI:Reports that he has had neck and back pain for "several weeks" and has been treated for this condition by his PCP, and states that Tramodol, T-3's do not help.

Current Medications:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
2)	FLUOXETINE 20 MG CAP TAKE ONE CAPSULE BY MOUTH TWICE A DAY WITH MEALS	ACTIVE (S)
3)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
4)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
5)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)
6)	TRAMADOL 50MG TAB TAKE TWO TABLETS BY MOUTH THREE TIMES A DAY AS NEEDED AS NEEDED FOR PAIN	ACTIVE (S)

Allergies:
Patient has answered NKA

Subj. ROS:
Head: Denies HA, Dizziness, Masses or Seizures
Eyes: Denies Visual Changes or Field Defects
Ears: Denies Tinitus, Vertigo, or Hearing Loss
Nose: Denies Nosebleeds, Discharge, or Sinus Diseases
Throat: Denies Dental Disease, Hoarsness or Throat Pain
Neck: Denies Stiff Neck or Masses
Heart: Denies CP, DOE or PND
Lungs: Denies SOB, Cough or Sputum Production
GI: Denies Dysphagia, Abd Pain, N/V/D, constipation or Melena
GU: Denies Dysuria, Frequency, Hematuria or Erectile Dysfunction
Skin: Denies Lesions or Easy Bruising
MSK: Admits to c-spine pain Joint Pain, Edema, Arthritis or Myalgias
Neuro: Denies Weakness, Seizures, Memory Changes, Depression, or Anxiety

Vital Signs: T:99 F [37.2 C] (03/02/2008 12:06) HR:73 (03/02/2008 12:06) RR:20 (03/02/2008 12:06) BP:129/85 (03/02/2008 12:06) Pain:9 (03/02/2008 12:06)

Obj. ROS:
Head: AT/NC, no masses
Eyes: Perrla, Eomi, no Icterus or Pitosis
Ears: TM's Intact, landmarks Visible
Nose: Septum Midline, no Nasal Discharge
Throat: No Erythema or Edema, or Dental Cavities
Neck: Supple, No JVD, Thyromegly, Masses or Bruits
Chest: CTA, Expands Symetrically, No Rales Rhonchi or Wheezes
Heart: RRR, No Murmurs
Abd: No Tenderness, Masses, Hepato/Splenomegly, Pos. BSx4 Quads
GU: No Inguinal Masses, Hernias, or Scrotal/Testicular Tender.
Skin: No jaundice, Brusing or Lesions noted
MSK: Pain increases with palpation, r/lateral rotation of neck, no ecchymosis, edema noted Full AROM with slight increase in pain.
Neuro: CN 2 to 12 Grossly Intact, Rhomberg Nl, Gate Steady

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

EDICAL RECORD

3/02/2008 12:39 ** CONTINUED FROM PREVIOUS PAGE **

ain: 9 (03/02/2008 12:06)
o you have pain?yes If yes, choose a number from 0 to 10 that best describes our pain
9

If the patient answers yes, complete the following assessment:

Where is the location (or locations) of your pain?
CERVICAL NECK, POSTERIOR

Describe what your pain feels like?
Sharp
When did the pain start?2 DAYS

Is the pain always there or does it come and go?
Pain always there
What makes the pain worse?N/A

What makes the pain better?N/A

Does the pain affect the following activities?

Other:

Present medications or treatments used for pain and their effectiveness:
(Include VA, non-VA, and store bought):NONE

Over-the-counter meds:

Potential barriers to reporting pain and/or using analgesics:

None
Other:

What is your pain goal? (from 0-10)
0

Interventions:
Patient referred to physician in outpatient

Disposition: Urgent
PATIENT SAFETY ASSESSMENT: Implement the Fall Prevention Protocol for any patient who scores 10 or more points.
Patient reports no history of recent falls...0 points

Fall Risk Score - 0 points

Protocol Indicated: No

Signed by: /es/ MARY J FILIPKOWSKI
RN BSN
03/02/2008 12:43

03/02/2008 12:43 ADDENDUM STATUS: COMPLETED
SOFT CERVICAL COLLAR APPLIED, DISCHARGED FROM ER WITH MEDS.
Signed by: /es/ MARY J FILIPKOWSKI
RN BSN
03/02/2008 12:43

M265

Progress Notes

MEDICAL RECORD

<< Interdisciplinary Note - Begin >>
ENTRY DATED: 03/02/2008 12:39
LOCAL TITLE: 1010M NURSING ASSESSMENT(PARENT)
STANDARD TITLE: NURSING TRIAGE NOTE
VISIT: 03/02/2008 10:51 ER (AM) CLINIC
Job #07-18
Approved 7-16-07

1010m Nursing Entry
This 30 year old MALE presented for benefits.
Patient Accompanied By: SPOUSE
The arrival mode was Ambulatory.
Patient's telephone number is PATIENT PHONE - 570-489-7276

Do you have any contraband (knives, razors, guns, swords, mace(pepper spray)or any sharp objects that can cause injury? No.

Homeless Status:
The patient is NOT homeless.

Vitals:
Temp: 99 F [37.2 C] (03/02/2008 12:06)
Pulse: 73 (03/02/2008 12:06)
Respirations: 20 (03/02/2008 12:06)
B/P: 129/85 (03/02/2008 12:06)

ALLERGIES:
Currently documented Allergies:
Patient has answered NKA
Visit Injury/Non-injury related: Today's visit was due to injury.

CURRENT MEDICATIONS:
VA medication Profile; Active Outpatient Medications (including Supplies):

	Outpatient Medications	Status
1)	CYCLOBENZAPRINE 10MG TABLET TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	PENDING
2)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
3)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
4)	PROPOXYPHENE N 50MG & ACETAMINOPHEN TAB TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED	PENDING

CAPSAICIN 0.075% CREAM (GM)
Sig: APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA
Fill Date: FEB 15, 2008

FLUOXETINE 20 MG CAP
Sig: TAKE ONE CAPSULE BY MOUTH TWICE A DAY WITH MEALS
Fill Date: FEB 11, 2008

MULTIVITAMIN TABLETS
Sig: TAKE 1 TABLET BY MOUTH EVERY DAY
Fill Date: JAN 10, 2008

TRAMADOL 50MG TAB
Sig: TAKE TWO TABLETS BY MOUTH THREE TIMES A DAY AS NEEDED AS NEEDED FOR PAIN
Fill Date: FEB 25, 2008

Non-VA Medications:

TRIAGE:
Data: SUSTAINED SEIZURE 2 DAYSA GO, SEEN AT mOSES TAYLOR HOSPITAL, NOW C/O CERVICAL NECK PAIN WITH NO RADIATION.

Assessment: PAIN

Plan: ER

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/03/2008 13:24
LOCAL TITLE: NSG CLINICAL REMINDER NOTE
STANDARD TITLE: EDUCATION NOTE
VISIT: 03/03/2008 13:00 ZZZPATEL I PRICARE
Preventive Health Screen:
Annual Preventive Health Screen Information

ALTERNATIVE THERAPY INFORMATION
No Herbal/Alternative Therapy taken.
No 'Over the Counter" drugs taken.
HYPERTENSION/OBESITY
Patient's BMI is <21 or >25. Current BMI: 29.3
Patient has been diagnosed with hypertension, diabetes mellitus or has a BMI <21 or >25. Indicate if patient has been evaluated by a dietitian in the past year.
Patient HAS NOT been evaluated by a dietitian in the past year.
Patient declines Nutrition Clinic consult.

ALLERGY INFORMATION
Patient states 'No Known Allergies". Primary Care provider must enter this information in CPRS.
SAFE IN HOME ENVIRONEMENT QUESTIONS
Patient feels safe in home environment.
PULMONARY
Patient does not use an inhaler/nebulizer.
ADL QUESTIONS
Patient DOES NOT need assistance with ADL.
Patient reports NO decrease/loss of self-care skills within past month.
Patient reports NO decrease/loss of mobility within past month.
Patient reports NO difficulty in swallowing.
DIABETES QUESTIONS
Patient IS NOT diabetic.
SEATBELT/HELMET SAFETY QUESTIONS
Do you wear a seatbelt when driving or riding in a car?
Comment: Yes

PREVENTIVE HEALTH EDUCATION SECTION
Education Topic & Level of Understanding
Individual Selection of Topics
Breast self exam education.
Level of Understanding: Good
Patient had alcohol abuse education at this encounter.
Level of Understanding: Good
Tobacco risk education.
Level of Understanding: Good
Patient had education on Exercise risks and benefits at this encounter.
Level of Understanding: Good
Patient advised to wear helmet when riding a bike or motorcycle, and to use seatbelts when driving in a vehicle.
Barriers to Learning Section
PATIENT EDUCATED - NO BARRIERS

Signed by: /es/ AMBER R KELLY
LPN
03/03/2008 13:28

M267

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/03/2008 13:28
LOCAL TITLE: NSG NURSING NOTE(T)
STANDARD TITLE: NURSING NOTE
VISIT: 03/03/2008 13:00 ZZZPATEL I PRICARE
Vital Signs:

TEMPERATURE: 98.6 F [37.0 C] (03/03/2008 13:23)
PULSE: 86 (03/03/2008 13:23)
RESPIRATION: 18 (03/03/2008 13:23)
BP: 127/80 (03/03/2008 13:23)
PAIN: 9 (03/03/2008 13:23)

DATA: presents for follow-up states he had a "seizure" 2/29/08 went to moses tyler in scranton he was told the seizure was caused by use of tramadol and prozac together was treated and released. now reports pain in neck radiating to right side that is relieved by flexaril but he can not tolerate it

ASSESSMENT: health seeking behavior

PLAN: informed vet. to get test results from moses tyler for MD refer to PCP

Signed by: /es/ AMBER R KELLY
LPN
03/03/2008 13:34

M268

[redacted] WILKES-BARRE VAMC
Pt Loc: OUTPATIENT

Printed: 06/29/2009 15:30
Vice SF 509

Progress Notes

MEDICAL RECORD

03/03/2008 13:56 ** CONTINUED FROM PREVIOUS PAGE **

clear. The heart is not enlarged. Mild degenerative change noted within the thoracic spine.

A/P:
neck pain appear to be consistent with strained muscle
tylenol # 3 every 6 hr prn pain also advised for rest, apply capsain cream as well as to use heating pad.
follow up with physical therapy

Patient was explained side effects of the medications, which he understood and verbalized. Plan of therapy was discussed with the patient, and he was agreeable.

Preventative - counselled regarding weight loss/exercise/smoking cessation/Diet

LABS: CBC w/diff, lipid profile, Chem profile - before next visit.
RTC: as schedule to Primary Care Clinic or early if necessary

PROVIDER POSITIVE DEP SCR F/U:
PHQ-9 Depression screen:
Scoring: 0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	0
2. Feeling down, depressed, or hopeless	0
3. Trouble falling/staying asleep sleeping too much	0
4. Feeling tired or having little energy	0
5. Poor appetite or overeating	0
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0
7. Trouble concentrating on things, such as reading the newspaper or watching television	0
8. Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0
9. Thoughts that you would be better off dead or of hurting yourself in some way	0

Total score = 0

PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Outpatient medications with doses or frequency changes. See Plan of Care above. Patient verbalizes understanding of medication dose or frequency changes.

Signed by: /es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
03/03/2008 14:19

M269

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/03/2008 13:56
LOCAL TITLE: MED PRIMARY CARE NOTE
STANDARD TITLE: PRIMARY CARE NOTE
VISIT: 03/03/2008 13:00 ZZZPATEL I PRICARE
CHIEF COMPLAIN: follow up on chronic medical problems.

HISTORY OF PRESENT ILLNESS: LASKOWSKI,STANLEY P III, is a 30 year old veteran came to my clinic today for a regular scheduled visit. for detail refer my note dated 02/15/2008. pt presents for follow-up states that he had a "seizure" 2/29/08 went to moses tyler in scranton he was told the seizure was caused by use of tramadol and prozac together was treated and released, no official report available. now he reports pain in rt side of neck that is relieved by flexaril but he can not tolerate it, pt is not taking tramadol and prozac as advised to discontiuue, pt was referred to ortho advise for physical therapy, referral pending, pt is advised to continue for tylenol #3 for now, physical therapy to follow up.

Subjective: Denies any chest pain, shortness of breath, cough, fever, chills, headache, dizziness, palpitation, abdominal pain, diarrhea, constipation, melena, bright red blood per rectum, hematuria, urgency, dysuria, weakness, blurred vision, slurred speech, sensory loss or any other complaints.

Allergies: Patient has answered NKA
MEDICATIONS:
Active Outpatient Medications (including Supplies):

Active Outpatient Medications	Status
1) CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
2) KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
3) METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE (S)
4) MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE

Pending Outpatient Medications	Status
1) ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	PENDING

PMH:
Posttraumatic Stress Disorder (ICD-9-CM Hip Pain

OBJECTIVE:
VITALS: T-98.6 F [37.0 C] (03/03/2008 13:23), P-86 (03/03/2008 13:23), RR- 18 (03/03/2008 13:23), BP-127/80 (03/03/2008 13:23)
GENERAL: alert and oriented, afebrile, comfortable, not in any distress.
SKIN: no jaundice, no pallor, no cyanosis, dry, non-scaly
HEENT: NCAT, anicteric sclerae, pink conjunctiva, PERRLA, moist oral mucosa.
NECK: supple, no JVD, no carotid bruit, no lymphadenopathy/ thyromegaly.
CHEST: Symmetrical, nontender.
LUNGS: Clear bilatereally, no rales/wheezes
HEART: s1 s2, regular, no murmur/gallop.
ABD: flat, soft, NABS +, nontender, no organomegaly/masses appareciated.
EXTS: warm, no edema/cyanosis/clubbing, good peripheral pulses
CNS: AAO x 3, no focal deficits noted.

LABS: reviewed.

INVESTIGATIONS:
*** Exam date: DEC 05, 2007@07:50 Proc: CHEST 2 VIEWS PA&LAT ***

*** IMPRESSION TEXT: ***

1. No active disease process is evident radiographically.

*** REPORT TEXT: ***
Findings: PA and lateral views are obtained. The lung fields are

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/04/2008 10:56
LOCAL TITLE: TLCP OIF/OEF
STANDARD TITLE: OEF/OIF TELEPHONE ENCOUNTER NOTE
VISIT: 03/04/2008 10:56 TLCP OIF/OEF
Data: Phone call rcvd from vet. Vet states he was seen at Moses Taylor on friday because of seizure activity. Vet was encouraged to stop taking his Prozac & Tramadol, which he complied. Vet concerned because he had not taken any Antidepressants since Friday and was attempting to obtain an appt with Psychiatry but is unable to be seen until 4/1/08. I spoke with Dr. Bhatia and she felt pt should be seen in order to evaluate the "c/o seizure activity" and possible medication adjustment. Because of the unavailability in Dr. Bhatia's clininc today, vet was encouraged to go to the Triage area to be seen by MHC today. Vet stated he would come to the triage area and was thankful for the assistance.

Signed by: /es/ SANDRA DOMPKOSKY RN MSN
OIF/OEF RN Case Manager
03/04/2008 11:26

M271

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/04/2008 14:52
LOCAL TITLE: NSG TRIAGE
STANDARD TITLE: NURSING TRIAGE NOTE
VISIT: 03/04/2008 14:40 TRIAGE-BASEMENT
TRIAGE (UNSCHEDULED): NON-URGENT

ALLERGY: Patient has answered NKA

LATEX ALLERGY: NO
Patient states he is also allergic to:

Do you feel safe in your home environment? Yes

Active Outpatient Medications (including Supplies):

ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)

T: 98.1 F [36.7 C] (03/04/2008 14:50)
P: 87 (03/04/2008 14:50)
R: 18 (03/04/2008 14:50)
BP: 133/76 (03/04/2008 14:50)
PAIN: 0 (03/04/2008 14:50)
PULSE OXIMETRY:

MODE OF ARRIVAL: AMBULANT

DATA: VET TOLD TO COME IN TODAY FOR POSSIBLE MED ADJUSTMENT OF ANTIDEPRESSANT MEDS THAT HE WAS TOLD NOT TO TAKE DUE TO SEIZURE ACTIVITY ON FRIDAY.

ASSESSMENT: NO COMPLAINTS TODAY

PLAN: MHC-CRISIS WORKER NOTIFIED.

PAIN ASSESSMENT
Do you have pain?

Signed by: /es/ CHARMAINE KUJAWSKI
RN
03/04/2008 14:55

M272

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/04/2008 15:54
LOCAL TITLE: PROVIDER MEDICATION RECONCILIATION NOTE
STANDARD TITLE: E & M NOTE
VISIT: 03/04/2008 16:00 MHC BHATIA CMI
PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Comment: Celexa

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/04/2008 15:55

M273

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/04/2008 15:56
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 03/04/2008 16:00 MHC BHATIA CMI
SUBJECT: phe

Patient came in for an unscheduled visit. He states that he recently suffered seizures along with loss of consciousness and was taken to the local hospital where they informed him that he probably had a seizure episode due to a combination of Ultram and Prozac. He has since visited his primary care physician and has been taken off both these medications. Patient has already been tried on several other antidepressants in the past including BuSpar, Remeron, trazodone, Ambien CR, Effexor XR, Paxil, Wellbutrin, and most recently Prozac. He has had a variety of different side effects from each of these medications. After much discussion, it was eventually decided to start him on Celexa. Patient is agreeable to starting the same since he is worried about not being on any antidepressant at all. He states that he finds it very difficult to motivate himself to carry through his daily routine. He stated that he initially did very well with the Prozac but gradually lapsed into feeling irritable and did not seem to derive the same benefit from his Prozac. He is now rather worried about continuing it and has already stopped taking the same. Patient was receptive to psychotherapy. He does have a followup appointment scheduled next month and is willing to follow through with the same. He was informed of the potential benefits and side effects of this medication and is willing to give it a trial.

MENTAL STATUS EXAMINATION: Patient is awake, alert, and oriented to person, place, and time. He is currently calm, pleasant, cooperative, and verbal. He denies suicidal or homicidal ideation but does admit to feeling fatigued and unmotivated from time to time. Patient is coherent, relevant, and goal-directed. He displayed fair memory, concentration, and attention span as well as fair judgment and insight.

ASSESSMENT: POSTTRAUMATIC STRESS DISORDER.

PLAN: Patient's Prozac has already been discontinued. He will be started on Celexa 10 mg p.o. q.a.m. for 10 days, followed by an increase in dose to 20 mg p.o. q.a.m. thereafter. He will return for further followup within the next 4 weeks.

AB/OSi/227414/0/03/04/2008 16:09:53/lp/D:03/04/2008
16:00:10/T:03/04/2008
16:09:53/VAJob#:1396229/IChartJob#29226411/23208354

Signed by: /es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/04/2008 16:34

M274

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/07/2008 14:30
LOCAL TITLE: PHYSICAL THERAPY OUTPATIENT EVALUATION
STANDARD TITLE: PHYSICAL THERAPY OUTPATIENT INITIAL EVALUATION NOTE
VISIT: 03/07/2008 14:00 PT-AMS/2ND FLR SILVER AREA
D: 30 y/o male vet, 5'8" and 192#, referred to PT for intermittent pain R upper traps/levator scapula/rhomboid minor area, started after reaching for something approx. 5 months ago. NSC visit.

PMHx: 10% SC tinnitus, 10% SC bursitis, 20% SC limited extension of forearm, 0% SC malunion of ankle, 10% SC chronic frontal sinusitis, 100% SC PTSD, h/o seizure activity, adjustment disorder, skin rashes, R hip bursitis, L hip greater trochanteric bursitis, R arm fx, R heel spur, hearing loss, concussion sec. to MVA '94, nicotine dependence, opioid abuse in past

Pt. presented to clinic ambul. without AD, AAOx3, cooperative. Does not appear to be in any acute distress. Reports having no pain at this time but does get pain/spasms with reaching/pushing activities involving his UE's. Was prescribed tylenol #3 but pt. states he doesn't like to it. Has tried capsacin but can not tolerate it because of it tends to cause a burning feeling. Using applications of heat has been helpful. Pt. does not work, on disability for PTSD. Denies paresthesia b/l UE's.

Posture: sits slumped w/drooping of shoulders

Cervical AROM: all motions WNL's, symptom free

AROM: b/l UE's WFL's with 4+/5 strength

DTR's: b/l UE's intact and appear symmetrical

Sensation: b/l UE's intact to crude/light touch, denies paresthesia

Palpation: trigger point tenderness noted at R levator scapula/rhomboid minor and R upper trap areas, tightness also noted R upper traps

Assess: pt. with c/o intermittent spasms R side of neck sec. to postural deficits/muscle strain, palpable trigger points noted R upper traps/rhomboid minor areas

Pt's goal: resolve episodic spasms R side of neck

PT goals:
- resolve episodic spasms R side of neck (upper traps, levator scapula rhomboid minor areas)
- pt. to demonstrate better postural awareness
- I HEP

Plan: Tips on improving postural awareness were discussed w/pt. Also advised continuation of home applications of heat f/b self stretching techniques. Cervical retraction, levator scapula stretch, upper traps stretch, and lower cervical/upper thoracic stretch were instructed. 5 sec. hold, 10 reps 2-3x/day. Ex. handout issued. Will f/u in 3-4 wks.

Potential: good
Frequency and Duration: PT eval plus f/u x 1 session.

Length of today's visit = 35 min. (initial PT eval = 20 min.)
(15 min. ex. instructions/pt. education)

Statement of Certification: I certify the need for these services furnished under this Plan of Treatment and while under my care.

Signed by: /es/ CHRISTINE V CAPUTO,PT
Physical Therapist
03/07/2008 15:41

Cosigned by: /es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
03/07/2008 16:24

M275

[redacted] [redacted] CONSULTATION SHEET

MEDICAL RECORD Progress Notes

LASKOWSKI,STANLEY P III [redacted] WILKES-BARRE VAMC Pt Loc: OUTPATIENT Printed:06/29/2009 15:30 Vice SF 509

M276

MEDICAL RECORD | CONSULTATION SHEET Page 3 of 3

Consult Request: Consult

Consult No.: 837421

(Scheduled Comment)
Entered by: NAYLOR,SANDRA A - 02/15/2008 2:26 pm
Responsible Person: PATEL,INDUBHAI M
Entered at: WILKES-BARRE VAMC
PT-AMS/2ND FLR SILVER AREA Consult Appt. on 02/27/08 @ 08:00
sam

(Status Change Comment)
Entered by: NAYLOR,SANDRA A - 02/25/2008 12:14 pm
Responsible Person: PATEL,INDUBHAI M
Entered at: WILKES-BARRE VAMC
PT-AMS/2ND FLR SILVER AREA Appt. on 02/27/08 @ 08:00 was cancelled by the Patien
Remarks: sam

(Scheduled Comment)
Entered by: NAYLOR,SANDRA A - 02/25/2008 12:14 pm
Responsible Person: PATEL,INDUBHAI M
Entered at: WILKES-BARRE VAMC
PT-AMS/2ND FLR SILVER AREA Consult Appt. on 03/07/08 @ 14:00
sam

M277

Consult Request: Consult | Consult No.: 837421

Consultation Results #6220009 continued.

D: 30 y/o male vet, 5'8" and 192#, referred to PT for intermittent pain R upper traps/levator scapula/rhomboid minor area, started after reaching for something approx. 5 months ago. NSC visit.

PMHx: 10% SC tinnitus, 10% SC bursitis, 20% SC limited extension of forearm, 0% SC malunion of ankle, 10% SC chronic frontal sinusitis, 100% SC PTSD, h/o seizure activity, adjustment disorder, skin rashes, R hip bursitis, L hip greater trochanteric bursitis, R arm fx, R heel spur, hearing loss, concussion sec. to MVA '94, nicotine dependence, opioid abuse in past

Pt. presented to clinic ambul. without AD, AAOx3, cooperative. Does not appear to be in any acute distress. Reports having no pain at this time but does get pain/spasms with reaching/pushing activities involving his UE's. Was prescribed tylenol #3 but pt. states he doesn't like to it. Has tried capsacin but can not tolerate it because of it tends to cause a burning feeling. Using applications of heat has been helpful. Pt. does not work, on disability for PTSD. Denies paresthesia b/l UE's.

Posture: sits slumped w/drooping of shoulders

Cervical AROM: all motions WNL's, symptom free

AROM: b/l UE's WFL's with 4+/5 strength

DTR's: b/l UE's intact and appear symmetrical

Sensation: b/l UE's intact to crude/light touch, denies paresthesia

Palpation: trigger point tenderness noted at R levator scapula/rhomboid minor and R upper trap areas, tightness also noted R upper traps

Assess: pt. with c/o intermittent spasms R side of neck sec. to postural deficits/muscle strain, palpable trigger points noted R upper traps/rhomboid minor areas

Pt's goal: resolve episodic spasms R side of neck

PT goals:
- resolve episodic spasms R side of neck (upper traps, levator scapula rhomboid minor areas)
- pt. to demonstrate better postural awareness
- I HEP

Plan: Tips on improving postural awareness were discussed w/pt. Also advised continuation of home applications of heat f/b self stretching techniques. Cervical retraction, levator scapula stretch, upper traps stretch, and lower cervical/upper thoracic stretch were instructed. 5 sec. hold, 10 reps 2-3x/day. Ex. handout issued. Will f/u in 3-4 wks.

Potential: good
Frequency and Duration: PT eval plus f/u x 1 session.

Length of today's visit = 35 min. (initial PT eval = 20 min.)
(15 min. ex. instructions/pt. education)

Statement of Certification: I certify the need for these services furnished under this Plan of Treatment and while under my care.

/es/ CHRISTINE V CAPUTO,PT
Physical Therapist
Signed: 03/07/2008 15:42

/es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
Cosigned: 03/07/2008 16:24

M278

198-66-7220 01/26/197[illegible] CONSULTATION SHEET

MEDICAL RECORD | CONSULTATION SHEET Page 1 of 3

Consult Request: Consult | Consult No.: 837421

To: PHYSICAL THERAPY-OUTPATIENT | Requested: 02/15/2008 2:20 pm
From: ZZZPATEL I PRICARE

Requesting Facility: WILKES-BARRE VAMC

Current Primary Care Provider: PATEL,INDUBHAI M
Current Primary Care Team: GENERAL MEDICINE

REASON FOR REQUEST: (Complaints and findings)
SERVICE CONNECTED % - 60

TINNITUS 10% SC
BURSITIS 10% SC
BURSITIS 10% SC
LIMITED EXTENSION OF FOREARM 20% SC
MALUNION OF ANKLE 0% SC
SINUSITIS,FRONTAL,CHRONIC 10% SC
POST-TRAUMATIC STRESS DISORDER 100% SC
PERIOD OF SERVICE - PERSIAN GULF WAR

COMBAT SERVICE - NO
Is patient an OEF/OIF returnee? No

Reason for Request: 30 y/o male with rt shoulder trigger point in rhomboid region, oterwise normal with negative inpingement sign, negative drop test and intact rotator cuff this appears to be consistent with strained muscle that has not resolved as per ortho note scanned document he should start physical therapy to rt shoulder area as advised by ortho, please evaluate and advise.

PROVISIONAL DIAG: rt shoulder strain

REQUESTED BY:	PLACE:	URGENCY:
PATEL,INDUBHAI M STAFF PHYSICIAN, PRIMARY CARE (Pager: 272) (Phone: 4885)	Consultant's choice SERVICE RENDERED AS: Outpatient	Routine

CONSULTATION NOTE #6220009

LOCAL TITLE: CONSULTATION REPORT
STANDARD TITLE: CONSULT
DATE OF NOTE: MAR 07, 2008@15:41 ENTRY DATE: MAR 07, 2008@15:41:39
AUTHOR: CAPUTO,CHRISTINE V EXP COSIGNER: PATEL,INDUBHAI M
URGENCY: STATUS: COMPLETED

SERVICE CONNECTED % - 60
TINNITUS 10% SC
BURSITIS 10% SC
BURSITIS 10% SC
LIMITED EXTENSION OF FOREARM 20% SC
MALUNION OF ANKLE 0% SC
SINUSITIS,FRONTAL,CHRONIC 10% SC
POST-TRAUMATIC STRESS DISORDER 100% SC
PERIOD OF SERVICE - PERSIAN GULF WAR

AUTHOR & TITLE: | DATE:

ID #:_____ | ORGANIZATION:WILKES-BARRE VAMC | REG #:____ | LOC: ZZZPATEL I

LASKOWSKI,STANLEY P III SERVICE CONNECTED 50% to 100% SC VETERAN
[redacted] M279 Phone: [redacted] CONSULTATION SHEET
Standard Form 513 (Rev 9-77)

Progress Notes

MEDICAL RECORD

03/09/2008 05:37 ** CONTINUED FROM PREVIOUS PAGE **

with the Toradol injection.

3. Screening for traumatic brain injury: As patient is an Operation Iraqi Freedom veteran and he states that he was very close in near distances of a few yards from grenade explosions and tank bomb explosions, and he believes that he had multiple episodes of concussions, although no definite direct head injury was noted. Patient has difficulty in sleeping. He does complain of intermittent headaches. He has some problem with memory according to him and sensitivity to bright light, and becomes irritable. He says he might have passed out, but he is not very sure about it. Patient has been screened for traumatic brain injury as described and I have put in an appropriate consult for traumatic brain injury by the TBI Team. I also gave the patient the number of Sandra Demkoski who is the TBI Coordinator to help this patient out, as well as her extension number for his traumatic brain injury consult.

I just spoke to Geisinger Medical Center, Danville. They will need some more information including his blood work. They do not expect that his patient will be accepted at least before 2 o'clock or so until they review the records with the psychiatrist, so we are trying to get another hospital to get a bed for this patient if we can.

d- 3/9/08 7:03 a.m.
J# 125878 TA12

Signed by: /es/ SANJAYKUMAR J DOSHI
STAFF PHYSICIAN(CARDIOLOGY)MEDICAL SERVICE
03/09/2008 14:03

M280

Progress Notes

MEDICAL RECORD

03/09/2008 05:37 ** CONTINUED FROM PREVIOUS PAGE **

Operation Iraqi Freedom traumatic brain injury and I have put in an appropriate consult for the same reason. His appetite is also intermittently low according to him. He denies any complaint of chest pain, palpitations, syncope, orthopnea, paroxysmal nocturnal dyspnea, visual disturbances, slurring of speech, or weakness of any extremity. The headaches are chronic headaches that intermittently come and go, lasting for a few seconds to a few minutes, sometimes several hours, not specifically any localized headaches identified by him. He moves his bowels very well. He denies any other complaint of bleeding from anywhere, hematuria, hematemesis, or melena. Physically he is fairly active. He takes care of his three children while at home and does some household chores without any problem. He has generalized body aches. He says his whole body is aching and noting groin pain. He could not identify any specific body part. He believes that many times it is mostly in the back area as well as well as in his hip area. However, there was no localized tenderness noted at any point.

Physical examination:
VITALS: Temperature 98.1, pulse 87 per minute, blood pressure 133/76.
HEAD: Atraumatic, normocephalic.
EYES: Both pupils equally reacting to light and accommodation. Eyes otherwise nonicteric.
EARS/NOSE/THROAT: Otherwise unremarkable.
NECK: Supple. No jugular venous distention or carotid bruit.
HEART: S1 and S2 regular. No murmur, gallop, or pericardial rub appreciated.
LUNGS: Bilateral good air entry. No rales or rhonchi.
ABDOMEN: Soft, nontender, nondistended. No hepatosplenomegaly or mass appreciated.
EXTREMITIES: No pedal edema noted. Distal pulses were 3+. No evidence of any acute ischemia noted.
NEUROLOGICAL EXAMINATION: Alert, awake, and oriented. Most memories intact both recent and remote. Cranial nerves II through XII are normal. Power in all extremities is 5/5. Reflexes were at least 2+ symmetrical both in upper and lower extremities including biceps, triceps, radial, knee, and ankle. Plantars both were downgoing. No focal sensory deficits noted. Coordination was normal. No cerebellar signs were noted. No sign of meningeal irritation was noted.
MUSCULAR EXAMINATION: Range of motion in both shoulders, elbow joints, and wrist joints within normal limits as well as knee, ankle, and hip joints. No localized focal tenderness was noted at any joint. No sign of any specific inflammation was noted. No rash of skin was noted at any joint. I could not find any specific point for localized tenderness in any part.

Assessment and plan:

1. Suicidal ideation earlier secondary to post-traumatic stress disorder: I discussed this case with Dr. Santos and he advised the patient to be on suicidal one-to-one watch. As we do not have any bed at the present moment, I spoke to the Nursing Supervisor, Pat, as recommended by Dr. Santos to find a bed in a local community hospital for this patient's care for his PTSD as well as for suicidal ideation and stabilization of his psychiatric issues. Patient has already signed 201 form for voluntary inpatient treatment for consent. Patient will be on one-to-one watch in the emergency room until we get a bed for him.

2. Chronic body pain: Exact etiology still needs to be determined. I have suggested to patient that once he is discharged from Psychiatric Service he needs to get in touch with his primary care physician for further evaluation for his generalized body pain as he describes and try to get help to get adequate pain control. Patient was obviously not able to tolerate Tylenol #3 as he says it did not do anything and he became irritable with that. He could not take tramadol because of drug interaction between tramadol and Prozac as well as citalopram. During this time I gave him a Toradol injection of 60 mg. intramuscularly and will see how he responds with the pain management, and I suggested patient to call us back and inform the Nursing Staff and see how he felt

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/09/2008 05:37
LOCAL TITLE: ER ATTENDING NOTE
STANDARD TITLE: EMERGENCY DEPT NOTE
VISIT: 03/09/2008 05:37 ER (MIDNIGHT) CLINIC

This 30-year-old gentleman presented to the emergency room today. Please refer to nursing note from today. Patient came to the emergency room because of pain medication withdrawal, saying he has generalized body aches since he was taken off his tramadol and Prozac because of a seizure which he had, and patient does not believe that citalopram is helping with his post-traumatic stress disorder. Earlier today he had a thought of harming himself, but since he came to the hospital tonight he has no more of those feelings and he did not have any specific plan of hurting himself.

This is an Iraqi War veteran who has a past medical history of: 1) Post-traumatic stress disorder for which he is service connected. 2) Also, he is service connected for tinnitus. 3) History of bursitis. 4) Chronic frontal sinusitis. 5) Generalized body pain for which he was taking in the past tramadol. Exact etiology for this body pain and generalized body aches is still undetermined. There is no prior history of myocardial infarction, coronary artery disease, congestive heart failure, angina, valvular heart disease, congenital heart disease, cardiac arrhythmias, chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebrovascular accident, or any cancer of major organs.

History of present illness: Today the patient said that earlier he was admitted in the Moses-Taylor Hospital emergency room on 2/29/08. According to him his seizure was witnessed by his wife and his father, and patient reported to the emergency room. They did a CAT scan of the head at that time as per patient which was negative. Patient was advised to be hospitalized, however, he signed out against medical advice at that time. He was informed that this seizure could be secondary to a combination of tramadol and Prozac. Hence, patient was advised to discontinue both of those medications and advised to follow up with this V.A. here with Psychiatry and Primary Care Services regarding his pain management as well as for PTSD. Subsequently, patient was seen by Dr. Patel on 3/3/08 and instead of tramadol was started on Tylenol #3. Also, he was seen on 3/4/08 by Dr. Bhatia who started him on citalopram at that time initially 10 mg. and after one week to increase to 20 mg. Please refer to her note of 3/4/08. In the past also patient had tried several different antidepressants as per Dr. Bhatia's note including BuSpar, amiodarone, trazodone, Ambien CR, Effexor, Paxil, Wellbutrin, and most recently Prozac, and he had some degree of side effects with each of these medications. Patient says since he was started on citalopram he did not feel any better and also he was having a lot of "body aches". Hence, he took Tylenol, sometimes taking multiple Tylenol tablets. He was prescribed only a total of three tablets per day, but he might have taken five, six, or so. Hence, his wife got concerned according to patient and she flushed all the Tylenol #3 tablets down the toilet as she was concerned that patient was becoming addicted to Tylenol #3. For the last few days patient says he has not taken any Tylenol #3 and he became more irritable, also.

Patient is also going through other stress including legal stress. He says he has an upcoming hearing with a judge on Monday for some criminal charges which have been filed against him which include felony charges, also. Patient says he is really stressed out.

Today in early morning or last evening, patient said that he wanted to hurt himself but since he came to the hospital he does not have any plan or wishes to do that.

He says intermittently he does get a headache. He also claims that he was in the Iraq War and many times a grenade had exploded very close to him, and he believes he also had a concussion. He has intolerance to light also particularly when he gets out of bed when he cannot tolerate light. He also feels sometimes being dazed or confused, and he now believes that his memory is not as great as before and he forgets stuff. He does have a sleep problem, also. Hence, patient was screened for

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Notes

MEDICAL RECORD

03/09/2008 05:44 ** CONTINUED FROM PREVIOUS PAGE **

felt that way. states that he came here for help and is not suicidal. spoke with dr. santos via phone. had signed a 201 earlier. left ama at 11:15am. was removed from 1:1 watch after speaking with dr. santos. dr. nassar also spoke with dr. santos. no suicidal ideation on discharge.

Signed by: /es/ CHARMAINE KUJAWSKI
RN
03/09/2008 11:52

M283

03/09/2008 05:44 ** CONTINUED FROM PREVIOUS PAGE **

Does the pain affect the following activities?

Other:

Present medications or treatments used for pain and their effectiveness:
(Include VA, non-VA, and store bought):
Over-the-counter meds:

Potential barriers to reporting pain and/or using analgesics:

Other:

What is your pain goal? (from 0-10)
0

Interventions:
Patient referred to physician in outpatient

Signed by: /es/ ROSEANNE M GAVIN
RN
03/09/2008 05:58

03/09/2008 06:59 ADDENDUM STATUS: COMPLETED
Pt given toradol 60 mg IM to RGM at 635 am. Pt tolerated well. 201 signed by pt for admission to psychiatry unit.
Signed by: /es/ ROSEANNE M GAVIN
RN
03/09/2008 07:00

03/09/2008 07:40 ADDENDUM STATUS: COMPLETED
Placed on 1:1 watch. Presently asleep. Awaiting placement. No psychiatry suicide watch bed available at this time.
Signed by: /es/ ROSEANNE M GAVIN
RN
03/09/2008 07:48

03/09/2008 08:47 ADDENDUM STATUS: COMPLETED
Labs drawn as ordered.
Signed by: /es/ ROSEANNE M GAVIN
RN
03/09/2008 08:48

03/09/2008 09:11 ADDENDUM STATUS: COMPLETED
Pt reports toradol somewhat effective and headache has decreased. "Growing pains in legs are the same". Slept approx 1/1/2 hrs. Cooperative and talkative at present.
Signed by: /es/ ROSEANNE M GAVIN
RN
03/09/2008 09:14

03/09/2008 11:48 ADDENDUM STATUS: COMPLETED
patient had been on 1:1 watch entire time in er. pleasant and co-operative while here. denies suicidal ideation while here. states he was asked if he felt like dying while he was in pain earlier in the nite and states that at that ime he

** THIS NOTE CONTINUED ON NEXT PAGE **

M284

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/09/2008 05:44
LOCAL TITLE: NSG TRIAGE
STANDARD TITLE: NURSING TRIAGE NOTE
VISIT: 03/09/2008 05:37 ER (MIDNIGHT) CLINIC
TRIAGE (UNSCHEDULED): NON-URGENT

ALLERGY: Patient has answered NKA

LATEX ALLERGY: NO
Patient states he is also allergic to:

Do you feel safe in your home environment? Yes

Active Outpatient Medications (including Supplies):

ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
CITALOPRAM 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY MORNING FOR 10 DAYS, THEN TAKE ONE TABLET EVERY MORNING AFTER MEAL	ACTIVE
KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)

T: 98.1 F [36.7 C] (03/04/2008 14:50)
P: 87 (03/04/2008 14:50)
R: 18 (03/04/2008 14:50)
BP: 133/76 (03/04/2008 14:50)
PAIN: 0 (03/04/2008 14:50)
PULSE OXIMETRY:

MODE OF ARRIVAL:

DATA: Pt came to Er due to "pain med withdrawals". States he has pain all over since doctor took him off his pain meds (tramadol and prozac). Pt feels citalopram is not helping. Pt had thoughts of harming himself earlier today but staes since he came to hospital tonight he does not have these feelings. Pt states he did not have a plan. Denies homicdal ideations. Pt is not intoxicated.

ASSESSMENT:Pt states wife flushed tylenol #3 down commode because he was getting addicted to them. Pt was taking 15 Tylenol #3 at a time.

PLAN: Disp to Er Md

PAIN ASSESSMENT

Do you have pain?yes If yes, choose a number from 0 to 10 that best describes your pain
7

If the patient answers yes, complete the following assessment:

Where is the location (or locations) of your pain?
all over

Describe what your pain feels like?
Aching Throbbing
When did the pain start?3 days ago

Is the pain always there or does it come and go?
Pain comes and goes
What makes the pain worse?being awake with no medication

What makes the pain better?tylenol #3 but pt was taking 15 at a time

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/09/2008 06:18
LOCAL TITLE: ER ATTENDING NOTE
STANDARD TITLE: EMERGENCY DEPT NOTE
VISIT: 03/09/2008 05:37 ER (MIDNIGHT) CLINIC

TBI Screening:
The patient reports service in Operation Iraqi Freedom.
The location of the patient's most recent OIF service was
Iraq

TRAUMATIC BRAIN INJURY SCREENING

Has the veteran already been diagnosed as having TBI during OIF/OEF deployment?
No

Section 1: The veteran experienced the following events during OIF/OEF deployment:
Blast or Explosion IED (improvised explosive device), RPG (rocket propelled grenade), Land Mine, Grenade, etc.

Section 2: The veteran had the following symptoms immediately afterwards:
Losing consciousness/"knocked out"
Being dazed, confused or "seeing stars"
Not remembering the event
Concussion

Section 3: The veteran states the following problems began or got worse afterwards:
Memory problems or lapses
Balance problems or Dizziness
Sensitivity to bright light
Irritability
Headaches
Sleep problems

Section 4: The veteran relates he/she is currently having or has had the following symptoms within the past week:
Memory problems or lapses
Balance problems or dizziness
Sensitivity to bright light
Irritability
Headaches
Sleep problems
Positive screen.
Consult ordered for TBI referral.

Signed by: /es/ SANJAYKUMAR J DOSHI
STAFF PHYSICIAN(CARDIOLOGY)MEDICAL SERVICE
03/09/2008 06:24

M286

Progress Notes

MEDICAL RECORD

NOTE DATED: 03/09/2008 06:38
LOCAL TITLE: PROVIDER MEDICATION RECONCILIATION NOTE
STANDARD TITLE: E & M NOTE
VISIT: 03/09/2008 05:37 ER (MIDNIGHT) CLINIC
PROVIDER Med Reconciliation:
Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Patient reports taking the following meds different than origianlly prescribed at this clinic visit. See Plan of Care above. Following medication review, patient verbalizes understanding of current medication regimen.

Signed by: /es/ SANJAYKUMAR J DOSHI
STAFF PHYSICIAN(CARDIOLOGY)MEDICAL SERVICE
03/09/2008 06:38

M287

03/09/2008 11:01 ** CONTINUED FROM PREVIOUS PAGE **

3)	CITALOPRAM 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY MORNING FOR 10 DAYS, THEN TAKE ONE TABLET EVERY MORNING AFTER MEAL	ACTIVE
4)	KETOROLAC 60 MG/2ML INJ INJECT 60MG INTRAMUSCULARLY NOW	ACTIVE
5)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
6)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)

Pending Outpatient Medications	Status
1) KETOROLAC INJ INJECT 60 MG INTRAMUSCULARLY NOW	PENDING
2) TRAMADOL 50MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	PENDING

8 Total Medications
Changes in medications (list medications):
tramadol 50 mg po q 8hr

Patient signed AMA , he was aware of the risk and complication by going AMA , withdrawal symptoms , seizure .
Patient was cleared by Dr Santos who interviewed.him over the phone .

Signed by: /es/ FAWAZ NASSAR MD
STAFF PHYSICIAN MEDICAL SERVICE
03/09/2008 11:07

M288

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/09/2008 11:01
LOCAL TITLE: 1010M ER/SPU CLINICIAN DISCHARGE INSTRUCTIONS(CHILD)
STANDARD TITLE: PHYSICIAN DISCHARGE NOTE
VISIT: 03/09/2008 05:37 ER (MIDNIGHT) CLINIC
Clinician Discharge Instructions:
Instructions

Discharge Instructions were given to LASKOWSKI,STANLEY P III on MAR 09, 2008.

Mode of Departure: Ambulatory

5 ** FUTURE APPOINTMENTS **

DATE/TIME	CLINIC (LOCATION)
MAR 31,2008@13:00	PT-AMS/2ND FLR SILVER ARE (2ND FLR ROOM C2-17)
APR 1,2008@11:30	MHC BHATIA(OA) (1ST FLR MHC(SILVER AREA))
JUL 9,2008@08:45	LAB3RDFLRWEST(SILVER AREA (3RD FLOR WEST SILVER AREA)

Aftercare sheet given: Yes.

Discharge dietary instructions: as before

Follow-up activity/limitations: No Restrictions

Condition: Satisfactory

What to do if symptoms worsen: (specify) come back to the ER

Patient Instructions: Take one tramadol every 8hr .
Follow up with MHC tomorrow .
Follow up with primary care provider in 1-3 days .

Patient/or patient's representative verbalizes understanding.

PLEASE NOTE: A copy of your ER visit can be made available upon request thru the office of Release of Information.

Patient

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS:

SIGNATURE OF PATIENT DATE

Signed by: /es/ FAWAZ NASSAR MD
STAFF PHYSICIAN MEDICAL SERVICE
03/09/2008 11:04

03/09/2008 11:05 ADDENDUM STATUS: COMPLETED
LASKOWSKI,STANLEY P III, a 30 year old MALE, seen for reconciliation of medications.

ALLERGIES/ADR: Patient has answered NKA

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
2)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD Progress Notes

NOTE DATED: 03/10/2008 10:10
LOCAL TITLE: TLCP SOCIAL WORK
STANDARD TITLE: TELEPHONE ENCOUNTER NOTE
VISIT: 03/10/2008 10:10 TLCP SOCIAL WORK SERVICE
Phone call made to veteran this morning to follow-up on AMA discharge from ER on 3/10/08. Veteran was not at home, did speak to his mother. Review of records reveals that he has a court hearing this morning. Left a message with his mother to call this worker when he gets home. Also called his cell phone, there was no answer, did leave a message for him to call this worker. Will attempt to reach veteran throughout day and will try to bring him into MHC today. Dr. Bhatia was made aware of status.

Signed by: /es/ RONALD J SIMON
Local Recovery Coordinator
03/10/2008 10:15

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/10/2008 11:44

Receipt Acknowledged By:
/es/ Colleen M. Kaskel, MSN, RN
Acting OIF/OEF Program Coordinator
03/10/2008 11:18

03/10/2008 13:07 ADDENDUM STATUS: COMPLETED
Veteran returned phone call to this worker. He reports his hearing went well this am, and it looks like he will be accepted into the ARD program. He reports that he feels the incident in the ER was a misunderstanding. He states he was not suicidal at the time, that he had a vague thought the night before. He states he is not presently suicidal. He states he did not want to sign into the hospital, and again did not fully understand the process. He states he was withdrawing from pain medication and was looking for help for that issue. As stated he does deny any current suicidal thoughts. He is coming to see Dr. Patel today at 1:00 pm.; he agrees to come to MHC following that appointment.

Signed by: /es/ RONALD J SIMON
Local Recovery Coordinator
03/10/2008 13:12

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/10/2008 13:38

Receipt Acknowledged By:
/es/ Colleen M. Kaskel, MSN, RN
Acting OIF/OEF Program Coordinator
03/10/2008 13:20

Receipt Acknowledged By:
/es/ STEPHEN A SCHARDING, PA-C
PHYSICIAN ASSISTANT
03/11/2008 12:53

M290

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/10/2008 13:21
LOCAL TITLE: NSG NURSING NOTE(T)
STANDARD TITLE: NURSING NOTE
VISIT: 03/10/2008 13:00 ZZZPATEL I PRICARE
Vital Signs:

TEMPERATURE: 98.1 F [36.7 C] (03/04/2008 14:50)
PULSE: 90 (03/10/2008 13:20)
RESPIRATION: 18 (03/10/2008 13:20)
BP: 119/78 (03/10/2008 13:20)
PAIN: 2 (03/10/2008 13:20)

DATA: presents for follow-up to er visit 3/9 med changes made then, also scheduled to follow-up with mental health today. reports no reaccurences since leaving the ER

ASSESSMENT: health seeking

PLAN: refer to PCP

Signed by: /es/ AMBER R KELLY
LPN
03/10/2008 13:23

M291

Progress Notes

MEDICAL RECORD

03/10/2008 14:07 ** CONTINUED FROM PREVIOUS PAGE **

1. neck pain appear to be consistent with strained muscle
tylenol # 3 every 6 hr prn pain also advised for rest, apply capsain cream as well as to use heating pad.
continue physical therapy
2. POSTTRAUMATIC STRESS DISORDER.
follow up psych
3.traumatic brain injury
TBI referral pending
EEG to follow

Patient was explained side effects of the medications, which he understood and verbalized. Plan of therapy was discussed with the patient, and he was agreeable.

Preventative - counselled regarding weight loss/exercise/smoking cessation/Diet

LABS: CBC w/diff, lipid profile, Chem profile - before next visit.
RTC: as schedule to Primary Care Clinic or early if necessary

PROVIDER Med Reconciliation:
Outpatient Medication Review
No change in current medication at this clinic visit. Patient verbalizes understanding of current medication regimen.

Signed by: /es/ INDUBHAI M PATEL, MD
STAFF PHYSICIAN, PRIMARY CARE
03/10/2008 15:10

M292

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/10/2008 14:07
LOCAL TITLE: MED PRIMARY CARE NOTE
STANDARD TITLE: PRIMARY CARE NOTE
VISIT: 03/10/2008 13:00 ZZZPATEL I PRICARE
CHIEF COMPLAIN: follow up after recent ER vist and on chronic medical problems.

HISTORY OF PRESENT ILLNESS: LASKOWSKI,STANLEY P III, is a 30 year old veteran came to my clinic today for a regular scheduled visit. He has PMHx of ajustment Disorder, Posttraumatic Stress Disorder, Skin Rashes, Right Hip Bursitis, Left Hip: Greater trochanteric bursitis, Right arm Fracture, Chronic Left Hip Pain, sinusitis, Right heel Spur, Hearing Loss and Tinnitus. The patient is having persistent problems, despite anti-inflammatory medication. The patient states he injured his forearm when he fell on stairs in 2002. He was placed in a cast for two weeks. He has Right plantar calcaneus spur from radiology report. Pt also had Admission for Concussion due to Motor Vehicle Accidentin 1994. Patient was recently seen in the emergency room because of pain medication withdrawal, saying he has generalized body aches since he was taken off his tramadol and Prozac because of a seizure which he had, and patient does not believe that citalopram is helping with his post-traumatic stress disorder. pt was given tramadol which pt says that he did not took today doing ok, now pain is much improved on tylenol, he is getting physical therapy with improvement in pain, pt denies any acute compain today.

Subjective: Denies any chest pain, shortness of breath, cough, fever, chills, headache, dizziness, palpitation, abdominal pain, diarrhea, constipation, melena, bright red blood per rectum, hematuria, urgency, dysuria, weakness, blurred vision, slurred speech, sensory loss or any other complaints.

Allergies: Patient has answered NKA
MEDICATIONS:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
2)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
3)	CITALOPRAM 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY MORNING FOR 10 DAYS, THEN TAKE ONE TABLET EVERY MORNING AFTER MEAL	ACTIVE
4)	KETOROLAC 60 MG/2ML INJ INJECT 60 MG INTRAMUSCULARLY NOW	ACTIVE
5)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE
6)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE (S)
7)	TRAMADOL 50MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE

PMH:
Posttraumatic Stress Disorder (ICD-9-CM Hip Pain
Tobacco Use Disorder, Continuous

OBJECTIVE:
VITALS: T-98.1 F [36.7 C] (03/04/2008 14:50), P-90 (03/10/2008 13:20), RR- 18 (03/10/2008 13:20), BP-119/78 (03/10/2008 13:20)
GENERAL: alert and oriented, afebrile, comfortable, not in any distress.
SKIN: no jaundice, no pallor, no cyanosis, dry, non-scaly
HEENT: NCAT, anicteric sclerae, pink conjunctiva, PERRLA, moist oral mucosa.
NECK: supple, no JVD, no carotid bruit, no lymphadenopathy/ thyromegaly.
CHEST: Symmetrical, nontender.
LUNGS: Clear bilatereally, no rales/wheezes
HEART: s1 s2, regular, no murmur/gallop.
ABD: flat, soft, NABS +, nontender, no organomegaly/masses appareciated.
EXTS: warm, no edema/cyanosis/clubbing, good peripheral pulses
CNS: AAO x 3, no focal deficits noted.

LABS: reviewed.

A/P:

M293

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Notes

03/10/2008 14:14 ** CONTINUED FROM PREVIOUS PAGE **

Outpatient Medication Review
A new medication is to be added after review of current medication profile at this clinic visit. See plan of care above. Patient verbalizes understanding of use of new medication(s).
Comment: Cymbalta
A medication is to be discontinued during medication profile review at this clinic visit. See Plan of Care above. Patient verbalizes understanding of discontinuation of medication(s).
Comment: Celexa

Signed by: /es/ STEPHEN A SCHARDING, PA-C
PHYSICIAN ASSISTANT
03/11/2008 14:28

Receipt Acknowledged By:
/es/ FRANCISCO F SANTOS, M.D.
STAFF PSYCHIATRIST BEHAVIORAL SVCS
03/12/2008 15:39

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/11/2008 15:57

03/12/2008 15:39 ADDENDUM STATUS: COMPLETED

Patient was seen disclaiming suicidal thinking, reason that he came to the ER was to get relief to the headache which he believed was resulting from tramadol withdrawal.

He denies significant depression but instead is reporting anxiety, feeling on edge and periodic nightmares but less in intensity and frequenecy as compared to last year.

He reported that he just came from his court hearing today to charges of thief of vicodin from a pharmacy.

After discussion on psychotropics noting that he failed trials to a number of them including SSRI, venlafaxine, he agreed to try cymbalta.

MSE: alert, ox3, good hygeine, mood was moderately nervous, speech was rapid tending to be circumstantial, no psychotic symptoms, denies s/h ideations long term and short-term memory were intact, judment is fair and insight is fair.

A/P: 1. trial with cymbalta 20 mg q other day.
2. MHC follow-up as scheduled for april.

Signed by: /es/ FRANCISCO F SANTOS, M.D.
STAFF PSYCHIATRIST BEHAVIORAL SVCS
03/12/2008 15:49

M294

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/10/2008 14:14
LOCAL TITLE: PSYCHIATRY GENERAL NOTE
STANDARD TITLE: PSYCHIATRY NOTE
VISIT: 03/10/2008 14:00 MHC BOROWSKI WALK IN
Chief Complaint: Referred to MH Walkin-pt report improvement in mood/anxiety since yesterday

Subjective: This pt is followed by Dr Bhatia for PTSD and was seen in ER for persistant headache, poor sleep and mood lability yesterday. He was placed on S/V/E for vague suicidal ruminations but suquently denies and precautions were withdrawn and he left AMA. He today feels he was misunderstood and denies any suicidal ideation, inent, plan or past attempts. He report past D+A abuse but has been clean x 6 months and is on probations now. He feels he's done poorly on several SSRI and asks that Celexa be D/C. He has mild depression and mood lability, poor sleep but denies any hallucinations or other psychotic thoughts.

Objective:

Mental Status: Alert and oriented x3. In good contact. Spontaneous, relevant and coherent. Mood neutral. Affect appropriate speech content. Eating well, sleeps poor. No psychomotor retardation. Denied suicidal and homicidal ideation. No hallucinations delusions or loosening of association noted. Memory including recent, remote, immediate recall and judgement are not clinically impaired. Insight and motivation fair.

MEDICATION REVIEW: Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 300MG WITH CODEINE 30MG TAKE 2 TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE
2)	CAPSAICIN 0.075% CREAM (GM) APPLY SMALL AMOUNT TOPICALLY TWICE A DAY AS NEEDED TO AFFECTED AREA	ACTIVE (S)
3)	CITALOPRAM 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY MORNING FOR 10 DAYS, THEN TAKE ONE TABLET EVERY MORNING AFTER MEAL	ACTIVE
4)	KETOROLAC 60 MG/2ML INJ INJECT 60 MG INTRAMUSCULARLY NOW	ACTIVE
5)	METHYLPREDNISOLONE 4 MG TABLETS..DOSEPAK TAKE TABLET(S) BY MOUTH AS DIRECTED ON DOSE PACK	ACTIVE (S)
6)	MULTIVITAMIN TABLETS TAKE 1 TABLET BY MOUTH EVERY DAY	ACTIVE
7)	TRAMADOL 50MG TAB TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED	ACTIVE

Allergies:
Patient has answered NKA

Assessment: PTSD

Service Connected problems treated

Plan: Change current regimen.
Will D/C Celexa at pt's request.
We discussed treatment options and risk/benefits and side effects of various medication including Depakote, which I recommended, pt declined this but subsequently saw Dr Santos, who recommended Cymbalta
Will Have SRA with Mr Simon today

** FUTURE APPOINTMENTS **

DATE/TIME	CLINIC (LOCATION)
MAR 24,2008@09:00	TBI HOGG (1ST FLR WEST BLUE AREA)
MAR 24,2008@10:00	NEURO(EEG)8TH FLR SILVER (8TH FLR WEST(SILVER AREA))
MAR 31,2008@13:00	PT-AMS/2ND FLR SILVER ARE (2ND FLR ROOM C2-17)
APR 1,2008@11:30	MHC BHATIA(OA) (1ST FLR MHC(SILVER AREA))
JUL 9,2008@08:45	LAB3RDFLRWEST(SILVER AREA (3RD FLOR WEST SILVER AREA)

Call as necessary and return to clinic as above with Dr. Bhatia

PROVIDER Med Reconciliation:

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD — Progress Notes

03/10/2008 15:00 ** CONTINUED FROM PREVIOUS PAGE **

cognitive restructuring; however, veteran continues to feel frustrated. He states that he will continue to go to see his counselor at the Veterans' Center on a regular basis, but he does not feel that he will come to the V.A. any more. He states he is going to seek the care of an outside psychiatrist. At his request, consulted with Dr. Bhatia. Dr. Bhatia did come in to session and both her and this worker spent time explaining medications and symptoms to veteran. Dr. Bahtia explained to veteran that at this point, a medication such as valium would not be a very good choice for his condition and it definitely would not be safe. She explained the risks versus the benefits. She educated veteran on the use of a benzodiazepine versus an SSRI. However, after further discussion at this, the veteran was still not pleased with the treatment plan. He explained to Dr. Bahtia that he was not going to take the Cymbalta; therefore, Dr. Bahtia recommended that he continue with the Celexa. However, veteran stated he did not wish to do this also. Again, he requested a benzodiazepine. Veteran discussed with Dr. Bhatia since he was having problems with medications, that if he was not going to follow treatment plan, then it might be efficacious for him to not take any medications at all. However, her preference would be for him to continue on the Celexa as she feels confident this will address his issues; however, he is frustrated that he must wait a few weeks for this dosing to become effective. Once again, he focuses on the need for a medication like valium and it was explained to veteran that this is not a good course of action again because of the side-effects and concern over possible addiction issues and how he will build up a tolerance to this medication and it will no longer be effective. Worked with veteran on focusing on long term goals versus short term.

Veteran reports history of having a seizure on 2/29/08, he states he was told that it was due to the combination of Tramadol and Prozac. Veteran does not feel that the Prozac was helping his PTSD symptoms and the Tramadol was also stopped. He was started on Celexa, however, he does not feel it is working. He also reports frustration that he does not want to wait "three weeks for it to start working". Veteran self describes getting addicted to Vicodin, Er note reveals that he was starting to abuse Tylenol #3. During suicide risk assessment veteran denies drug and alcohol use since 8/07. However, ER records reveal that blood alcohol level in ER on 3/9/08 was 1.4.

A: Post-traumatic stress disorder

P: At this point, veteran displays no 302 Involuntary Commitment grounds. He denies any thoughts of harming himself in any way. Veteran does not wish to sign a voluntary into the hospital. He states he is going to continue seeing his counselor at the Veteran's Center and once again, as stated, veteran was calm throughout session. However, during the conversation, veteran calmly stood up and stated he does not agree with the treatment plan at this point and that he wishes to pursue private psychiatric treatment. Veteran was made aware of twenty-four hour services that he can access at any time and at that point the veteran left the session and left the V.A.M.C.

D- 3/10/08 8:12
T- 3/11/08 6:57
T24
Job # 126368

Signed by: /es/ RONALD J SIMON
Local Recovery Coordinator
03/11/2008 11:52

Receipt Acknowledged By:
/es/ ARUNA BHATIA
STAFF PHYSICIAN BEHAVIORAL SVCS
03/11/2008 13:38

M296

MEDICAL RECORD — Progress Notes

NOTE DATED: 03/10/2008 15:00
LOCAL TITLE: SW-GENERAL NOTE
STANDARD TITLE: SOCIAL WORK NOTE
VISIT: 03/10/2008 15:00 ZZZMHC SINON SWS

The veteran is a 30-year-old, married male, seen today for a forty-five minute session. This is a service-connected visit.

Veteran comes in today following phone calls from this worker requesting him to come in for assessment following patient being seen in the Emergency Room over the weekend. The veteran over the weekend did sign a 201 in the Emergency Room due to suicidal thoughts; however, while waiting for a bed, the veteran signed out against medical advice and left the Emergency Room. This worker did speak to veteran during the day on the telephone. Originally when I called, he was at a court hearing. Veteran states that this court hearing was due to him breaking into a pharmacy in the past when he was addicted to Vicodin and tried to steal Vicodin. He states that the hearing went well and he is due to enter into an ARD Program. He is pleased with the outcome of this hearing.

Veteran reported he was coming to the V.A.M.C. today to see his primary care physician, Dr. Patel, to talk about issues related to pain medication. The veteran did agree to come to the Mental Health Clinic following that appointment for further assessment from his stressors over the weekend. Veteran did already see Steve Scharding, P.A.-C., and Dr. Santos. He was seen by this worker following those appointments so I could conduct a suicide risk assessment and assess the veteran's safety.

Veteran was cooperative with process even though he states he is very angry right now at the V.A. and he is unsure if he going to come back any more. When questioned the veteran about this, he states that he believes he had suicidal thoughts over the weekend because he was withdrawing from tramadol and he was not given any medication to help withdraw from this. He states he was having terrible withdrawal symptoms and he does not feel anything was done for him at the Emergency Room or today in his primary care appointment. He states that "they did not give me anything to stop the withdrawal." As stated, he also saw the P.A. and psychiatrist in Mental Health Clinic. He was also not pleased with that outcome. He states that Dr. Santos prescribed him Cymbalta 20 mg. to take one tablet every other day and veteran is not pleased with this treatment plan. He states that he feels Celexa was not helping prior to the Cymbalta so he does not believe that the Cymbalta will also help. He is, at this point, requesting to take valium. He states he has a friend who was in the military service with him and is having the same problems he is and valium is the only thing that is working for him. Veteran agreed to undergo the suicide risk assessment and then we will further assess problem areas.

Suicide assessment was completed, that is a separate note. Please refer to that note for details. However, during the assessment, the veteran stated that he does not believe he was truly suicidal when he came to the Emergency Room over the weekend. He states "I was withdrawing from the pain medication and thought maybe I would be better off dead rather than going through this." He states that thoughts were passive and he did not have any intent to carry them out. He also states that he did not have a plan. He currently denies any suicidal thoughts, plan or intent. He is future oriented. He states that he did not truly understand that he was signing a voluntary admission for psychiatric care and that he would have to stay until the doctor discharged him.

Mental status reveals that the veteran denies depression. He states that he is anxious over the current situation with his medications and still has some anxiety left over from the court hearing earlier today. He states that his sleep is poor, with not feeling rested. Appetite is fair. His thoughts are clear with no evidence of psychosis and he displays good controls during this interview even though he is angry with the situation as he describes it. His affect is calm. His voice is steady without raising it and he is relating his frustrations in an appropriate manner.

Supportive therapy was applied in this situation along with some

** THIS NOTE CONTINUED ON NEXT PAGE **

Progress Not

MEDICAL RECORD

03/10/2008 15:22 ** CONTINUED FROM PREVIOUS PAGE **

Signed by: /es/ RONALD J SIMON
Local Recovery Coordinator
03/10/2008 20:07

M298

MEDICAL RECORD — Progress Notes

03/10/2008 15:22 ** CONTINUED FROM PREVIOUS PAGE **

Drugs-type (specify) Veteran states he became addicted to Vicodin, has not used since 8/13/07.

Alcohol-frequency (specify) Has not used alcohol since 8/6/08.

9. Serious Medical Illness:

(a) Type: "Hip, knee, ankle and neck problems".

(b) Duration: "5 to 7 years".

10. PAIN - Chronic and Severe
Duration: Same as above.

Severity: (0-10) 2

Current Psychiatric Symptoms:

Depression No
Anxiety Yes

Hopelessness/Demoralization Yes, occasional

Hallucinations None

If command hallucinations present, describe

Delusions No
Type:

ASSESSMENT OF RISK FOR SUICIDE
Based on number of risk factors
Low
Non-Imminent

TREATMENT HISTORY:
Active treatment compliance

Treatment History comments: See history

TREATMENT PLAN

RECOMMENDATIONS TO TREATMENT TEAM:
INPATIENT

Patient Response to Intervention/Recommendations:

OUTPATIENT

Psychotherapeutic intervention (specify), Medication evaluation,
Other:

PATIENT RESPONSE TO INTERVENTION/RECOMMENDATION
Negative

For further details, please refer to my note of same date.

** THIS NOTE CONTINUED ON NEXT PAGE **